

THE ANOREXIC MASK:
A CASE STUDY OF A PATIENT WITH CO-MORBID
ANOREXIA NERVOSA AND FACTITIOUS DISORDER?

BY JEANNE GAYLARD

A thesis submitted in partial fulfillment of the requirements for the degree of

MASTER OF SOCIAL SCIENCES IN CLINICAL PSYCHOLOGY

Of

RHODES UNIVERSITY

SOUTH AFRICA

November 2002

“That a fellow human being should so damage herself and not want to be fed or recover is almost intolerable” (Farrel, 1995, p.60).

ABSTRACT:

This study is a case-study of a patient who was diagnosed as having co-morbid Anorexia Nervosa and Factitious Disorder. It would appear that central to an understanding of both of these disorders is *the patient's disturbed relationship to her own body*. The existing literature on co-morbid Factitious Disorder and Anorexia Nervosa is rare, with only three cases published. A careful reading of these cases suggests that in all of these cases, Factitious Disorder may have been the primary diagnosis. In this case there was an *over-identification with the patient role*, and the patient's anorexic symptoms appeared to serve the function of meeting the patient's acute dependency needs. Thus, the patient's Anorexia Nervosa *masked* the Factitious Disorder and appeared to be secondary to the Factitious Disorder. It is argued that these disorders share several common dynamics, namely the inability to separate from the mother, high parental expectations as well as the use of the body as a transitional or pre-cursor object. In addition there are some common dynamics in the psychotherapy of these patients. All of these factors suggest that in both these disorders the developmental arrest may be located at a *pre-verbal level*.

ACKNOWLEDGEMENTS:

I would like to convey my sincere thanks and appreciation to the following people:

To Ian Reid for his intuitive and supportive supervision.

To Professor Szabo for his insight and his knowledge.

To Professor Dave Edwards for the excellent consultation on the case study method.

To my friends Rene Durrbaum Brandt and Michael Border for their honest, thoughtful and helpful feedback.

To Vicky Vorster and all the staff at the Tara Eating Disorder Unit.

To Mandy Wilkinson who supervised this case when I was an intern.

To Mrs Stockwell at the Rhodes University Library who assisted me in finding literature.

To my husband Thurlow Hanson-Moore for his love and support.

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CHAPTER 1: INTRODUCTION.

In 2001, while the researcher was an intern psychologist at Tara Hospital's Eating Disorder Unit in Johannesburg, a patient was diagnosed as having co-morbid Factitious Disorder and Anorexia Nervosa. While there is a dearth of literature on cases involving co-morbid Anorexia Nervosa and Factitious Disorder, it would appear that central to both of these diseases is the patient's disturbed relationship to her own body. The focus of this study is an exploration into the links between these disorders and the underlying psychodynamics.

As a starting point, the literature review defines Factitious Disorder and Anorexia Nervosa. The existing literature on co-morbid Factitious Disorder and Anorexia Nervosa is then discussed. Such literature is rare; an extensive literature search indicated that, to the best of this writer's knowledge, only three cases have ever been published. While these studies emphasise that the Factitious Disorder and Anorexia Nervosa are co-morbid, a careful reading suggests that in all these studies, Factitious Disorder may have been the primary diagnosis.

The literature emphasises that difficulties with separation and individuation are central to understanding both Factitious Disorder and Anorexia Nervosa. Due to the fact that this research is an attempt to understand the underlying psychodynamics, the developmental theories of Mahler and Winnicott are outlined. Mahler's work is concerned with the process of separation and individuation. Winnicott is also concerned with the process of

contact and separation and his theory of transitional objects is explored as a means of understanding both the Factitious Disorder patient's and the Anorexic patient's relationship with her body. The literature pertaining to the psychotherapy of Factitious Disorder and Anorexia Nervosa is discussed. It will be argued that while these diseases may appear dissimilar, the literature highlights the fact that these disorders may present common challenges to therapists.

The patient J is then discussed utilising documents from her case file. The Results section is divided into three sections:

- (i) A description and discussion of the patient's history,
- (ii) A description and discussion of a detailed Psychological Assessment, and
- (iii) A description and analysis of psychotherapy notes and transcripts.

The case-study method is utilised. This method provides the researcher with a set of observations about the individual and enables the researcher to provide an in-depth and accurate description of the patient and also to conceptualise the case material in psychological terms. The case-study method enables the researcher to account for the reason the why the individual behaved as she did within a given circumstance.

The major themes that emerged in this study are the patient's enmeshed but depriving relationship with her mother, over-identification with the patient role, and the patient's disturbed relationship to her own body. The psychotherapy notes and transcripts further revealed the patient's difficulty in establishing rapport as well as difficulties with confrontation. Due to the patient's weight loss, and since many of the dynamics between

Factitious Disorder and Anorexia Nervosa appear to be similar, this patient was initially diagnosed as suffering from Anorexia Nervosa. However, in this case, this patient was not “frantically preoccupied with food and eating” (Bruch, 1978, p. 32). Rather, *the patient’s Anorexia Nervosa appeared to mask the patient’s Factitious Disorder.*

CHAPTER 2: LITERATURE REVIEW

2.1 Definition of Factitious Disorder

In 1951, Asher utilised the eponym Munchausen's Syndrome from the fictionalised adventures of Baron von Munchausen. The designation Munchausen Syndrome described patients who repeatedly seek medical care for factitious illnesses. He defined Munchausen's syndrome as follows:

- (i) "Imagined or manipulated symptomatology,
- (ii) Pathological invention of medical and social identities, complete with aliases, false biographies and a tendency towards status seeking, and
- (iii) Pathological peregrinating from hospital to hospital, accompanied by antisocial behaviour" (Asher, 1951, p.339-340).

According to Asher this syndrome was a common syndrome in that most doctors had had some experience with patients who exhibited these types of symptoms. Asher distinguished between different types of the illness, abdominal, hemorrhagic and neuralgic. Thereafter cases were reported and classified according to Asher's different types. As cases were reported, the term Factitious Disorder began to be used to discuss cases where patients did not have the sociopathic traits that had become associated with Munchausen's syndrome (Reich & Gottfried, 1983).

In general there is consensus about the clinical presentation of Factitious Disorder. The DSM IV (1994, p.471) outlines the essential feature of Factitious Disorder as the “intentional production of physical signs or symptoms” so that the patient may assume the sick role. The presentation may include the fabrication of subjective complaints, self-inflicted conditions, the exaggeration of pre-existing medical conditions, or any combination or variation of these. Unlike Malingering, in Factitious Disorder external incentives for the behaviour such as economic gain and avoiding legal responsibility are absent (DSM IV, 1994).

The patient with Factitious Disorder is also noted to present their history to health professionals with “flair” and to demonstrate a wealth of knowledge of medical terminology as well as of hospital routines. When questioned around the specifics of their history they may give vague or inconsistent answers or demonstrate pathological lying, *pseudologica fantastica* (DSM IV, 1994).

The DSM IV delineates three different subtypes of factitious disorder:

- (i) With predominantly psychological signs and symptoms,
- (ii) With predominantly physical signs and symptoms,
- (iii) With combined psychological and physical symptoms.

The course of Factitious Disorder is usually chronic and a pattern of successive hospitalisations may become a lifelong pattern.

Part of the problem with Factitious Disorder is that it is often difficult to diagnose and clinicians are often reluctant to make the diagnosis (Feldman, 1996; Stone, 1977). As Stone (1977, p.239) states:

“Factitious illness is a rarity and an oddity at the same time. Patients who feign obscure diseases fascinate as well as bedevil the medical profession. Their emotional disturbances, while usually severe, are elusive; they typically deny emotional illness, shy away from intensive examination, and as a consequence remain little known to the psychiatrist”.

While diagnosis often represents a diagnosis by exclusion, many writers have noted certain signs of Factitious Disorder. Paar (1994, p.43) has listed some of these signs in assisting the physician to make a diagnosis of Factitious Physical Disorder:

- (i) A history of illnesses accompanied by a long, unexplained course and multiple operations,
- (ii) Recurrent wound-healing disturbances,
- (iii) Wound healing disturbances contrary to the surgeons experience,
- (iv) Immunological and haematological symptoms pointing to the suspected diagnosis of a rare disease,
- (v) Exclusion of organic causes for impaired wound healing,
- (vi) Unclear indicators for the surgical procedure,
- (vii) Willingness to undergo surgery,
- (viii) Unusual psychic signs or symptoms,
- (ix) An average stay in hospital that is noticeably longer than that usually required,
- (x) Evidence of paraphernalia.

Paar has further noted that patients with Factitious Disorder have often had abdominal surgery. Further, there is a broader based literature that emphasises that patients with

Factitious Disorder make up dramatic or elaborate histories and describe a variety of factitious signs and symptoms in order to gain admission (Feldman, 1996; Feldman & Ford, 1994; Papadopoulos & Bell, 1999). Eisendrath (1996) writes that patients with Factitious Disorder are often able to forecast the prognosis or course of their illness and that these patients are often isolated from other patients and have few visitors.

Plassmann (1994) states that it is necessary to draw a distinction between the 'mimicry phenomenon' of Factitious Disorder and the auto-destructive behaviour of patients who cut or burn themselves. Plassmann (1994, p.11) argues that such patients present a different psychodynamic constellation in that auto-destructive patients are "far less inventive in their choice of manipulative methods" and that the injury takes place without the help of complicated aids:

"The injuries tend to be stereotyped in nature, without a particular personal symbolism. Munchausen Syndrome and patients suffering from Factitious Disorder erect an almost impenetrable psychic defense against the fact that they are inflicting injuries on their own bodies".

While this is the case it is important to note that many Factitious Disorder patients may also engage in some self-destructive behavior from time to time.

There is debate around the issue of deception in Factitious Disorder in that some writers emphasise the patient's deception (Feldman, 1996; Ford, 1973). Plassmann (1994, p.13), states that when working with a patient with factitious disorder, the patient's "*disturbed relationship to his or her own body*" needs to receive greater emphasis:

".....we find the strange pathology of a patient role which is the result of the patient's disturbed relationship to his or her own body and of the disturbed relationship to the physician."

Plassmann (1994) utilises the term 'mimicry phenomenon', to describe Factitious Disorders and is critical of writers' prejudice in that by focusing on deception, critical terms such as 'hospital hobo' and 'doctor shopping' result.

According to Nordemeyer (1994), the patient with Factitious Disorder may feign and or physically generate symptoms to attain the status of a patient who is ill. Nordemeyer further states that when treating patients with Factitious Disorder it is crucial to differentiate between those who feign illness and those who physically generate symptoms and as such 'manipulate' their bodies since the prognosis of those who induce illness is worse. Examples of manipulation include ingesting medication and infecting ones wounds. Eisendrath (1984) elaborates on this and emphasises that the level of enactment is important. The level of enactment is divided into three levels:

- (i) Fictitious, where there is no sign of illness,
- (ii) Simulation, where there is an appearance of illness, and
- (iii) Creation of illness. (Eisendrath, 1984, p.112).

According to Eisendrath (1996), the distinction between Factitious Disorder and Malingering is that in Factitious Disorder while the patient is aware that they are feigning or inducing an illness, the patient does not understand the reason for their actions. In Malingering, the patient may induce or simulate an illness for material secondary gain.

The DSM IV (1994, p.472) divides Factitious Disorders into three types:

- (i) With predominantly psychological signs and symptoms,

- (ii) With predominantly physical signs and symptoms,
- (iii) With combined psychological and physical signs and symptoms.

Many patients may have both psychological and physical symptomatology. This is elucidated by a patient of Dohn's (1986) who reported factitious rape and presented with psychological and physical symptoms. According to Nadelson (1996), the fact that most patients demonstrate both psychological and physical symptoms compounds the difficulty in diagnosing patients with Factitious Disorder. Like Eisendrath (1984), Parker (1996, p.42) suggests that the prognosis for Factitious Psychological Disorder may be better than that for Factitious Physical Disorder:

“These patients may be steps closer to successful treatment than their counterparts with physical symptoms because they acknowledge their need for mental health care. If the physician understands the factual content of a particular patient's complaint may still be tainted but addresses the distress of the patient, there is more likely to be a response to intervention. In contrast, patients with factitious physical symptoms are generally unable to discuss their feelings and thus may be less amenable to addressing their internal distress.”

Thus in sum the Factitious Disorder patient feigns or induces illness in order to assume the patient role. Central to an understanding of Factitious Disorder is the patient's *“disturbed relationship to his or her own body”* (Plassmann, 1994, p.13). Factitious Disorder differs from Malingering in that the Factitious Disorder patient does not understand why they are feigning or inducing illness. In contrast, malingerers hope to receive material gain. Most patients demonstrate both physical and psychological symptoms and this often makes the diagnosis of Factitious Disorder more difficult.

2.2 Definition of Anorexia Nervosa

According to Sours (1974), Anorexia Nervosa was recognised in the eleventh century and was not uncommon in the Middle Ages in that various religious practices involved self-starvation. In the seventeenth century Morton discussed “nervous atrophy”, a condition characterised by consumption, loss of appetite, amenorrhoea, emaciation and over activity. (Morton in Palazzoli (1978). However while anorexia existed prior to the seventeenth century, the incidence of anorexia has increased significantly in the 1960’s and 1970’s. Many theorists attribute the increase in anorexia as being inextricably linked to the emphasis on the ‘body beautiful’ as well as the pervasive confusion with the changing female role accompanied by pressure from the media (Hepworth, 1999; Malson, 1998).

The literature outlines the main feature of anorexia as being a dramatic decrease in weight. While this varies from patient to patient, the weight loss becomes apparent as the illness progresses. (Zerbe, 1992). Theorists have also emphasised that eating disorders involve a complex interplay of physical and emotional factors. Bruch (1973, p.6) delineated the symptoms of Anorexia Nervosa as follows:

- (i) “A relentless pursuit of thinness that is accompanied by body image disturbance of delusional proportions,
- (ii) A deficit in the accurate perception of bodily sensations. This is manifested as a lack of awareness and a denial of fatigue, and

- (iii) An all- pervasive sense of ineffectiveness. It is against this background of feeling helpless that the frantic preoccupation with controlling the body and its demands must be understood”.

Bruch (1978) stressed that while food intake is curtailed, anorexics are “frantically preoccupied” with food and eating. They regard the satisfying of their needs as shameful indulgence and consider self-denial and discipline as the highest virtue.

The DSM IV (1994) outlines the essential features of Anorexia Nervosa as the individual’s refusal to maintain a minimally normal body weight, an intense fear of gaining weight as well as a significant disturbance in the perception of the size of his/her body. Weight loss is typically achieved through reduction in food intake and most anorexics typically have a very restrictive diet, limited to only a few foods. Anorexics are very preoccupied with weight gain and may weigh themselves obsessively, or obsessively measure their bodies. The anorexic regards weight loss as an achievement whereas weight gain is seen as a failure of self-control. Anorexics deny the potentially serious repercussions of their malnourished state. In post-menarcheal females, there is amenorrhea due to the loss of estrogen. Anorexics are usually reluctant to seek help and family members typically bring anorexics to professional attention following weight loss (Bruch, 1978; Palazzoli, 1978; Zerbe, 1992).

The DSM IV describes two sub types of anorexia:

- (i) The restricting type,
- (ii) The binge-eating/ purging type.

In the restricting type, the anorexic loses weight through restricting the caloric intake or excessive exercise. In the binge-eating or purging type, the patient also binges and/or purges on a regular basis.

Thus the cardinal feature of Anorexia Nervosa is a dramatic decrease in weight. While food intake is usually curtailed, anorexics remain preoccupied with their bodies. There is a distortion of the body image and the anorexic regards weight loss as an achievement. Thus while in Anorexia Nervosa the patient also demonstrates a “disturbed relationship to her own body” (Plassmann, 1994), unlike the Factitious Disorder patient, the anorexic is usually a reluctant patient.

2.3 Co-morbid Anorexia Nervosa and Factitious Disorder:

Silber (1987) reported two cases of acquired pseudo eating disorder. These patients were hospitalised for other illnesses but fabricated symptoms of Anorexia Nervosa after having been exposed to patients with Anorexia Nervosa. Silber (1987, p.452) postulated that the patients perceived the symptoms of Anorexia Nervosa as being “amenable to control” in contrast to the reality of a threatening illness. In both of these patients, counseling resulted in a rapid resolution of the eating disorder symptoms. While these patients did not have co-morbid Factitious Disorder and Anorexia Nervosa, these cases are significant since they accentuate that patients may fabricate the symptoms of Anorexia Nervosa since the symptoms of Anorexia Nervosa are amenable to control.

An extensive literature search on co-morbid eating disorder and Factitious Disorder indicates that they are extremely rare with only three case studies ever being published.

The first literature on Factitious Disorder in Anorexia Nervosa appeared in 1992 (Burge & Lacey, 1992). Burge and Lacey's patient was diagnosed as having Anorexia Nervosa and Factitious Disorder. This patient had protracted family problems and reported that she felt inferior to her older sister who was her parents' favourite child. Moreover her father had sexually abused her from the age of eight until she was eleven years.

This patient became anorexic at age twenty coinciding with her first sexual relationship. At this time she restricted her food intake, utilised laxatives, and induced vomiting. Her weight fell from 63,5 kgs to 41,3 kgs and she was amenorrhic for some six months. At the same time that the anorexia began she reported that she had deliberately scalded herself as well as engaged in other self-injurious behaviours such as overdosing and cutting her arms and abdomen. She fabricated symptoms including pain in her neck, knee and abdomen and presented to at least twenty different hospitals giving false biographic details. She had four surgical operations for appendectomy, fusion of thumb joints, fusion of cervical vertebrae and an arthroscopy after she complained of pain.

Burge and Lacey (1992, p.379) argued that this patient utilised her Factitious Disorder symptoms, together with other self-damaging and addictive behaviours in order to "avoid anorexic feelings". This patient's Factitious Disorder was thus seen to be utilised as an "emotional defense" in an eating disorder in that "she enjoyed the feeling of being in

control of her symptoms and the fact that she had the ability to discharge herself from the hospital at will” (Burge & Lacey, 1992, p.380). The patient’s seemingly overwhelming need for nurturance and affection was highlighted with a concomitant fear of intimate relationships. Being in hospital gave this patient a way of satisfying her need for affection whilst being in control . The writers note that this patient “preferred a weekend in hospital to a weekend with friends” (Burge & Lacey, 1992, p.380). While in this case, the writers imply that Anorexia Nervosa was pre-eminent, what is unusual is the patient’s need to assume the patient role as well as the plethora of hospital admissions. This would suggest that the Factitious Disorder may have been the primary clinical diagnosis.

The second case was reported in New Zealand in 1996 (Bulik, Sullivan, Fear, & Pickering, 1996). In this study, a thirty-year-old patient received the diagnosis of Anorexia Nervosa, Bulimia Nervosa and Factitious Disorder. This patient reported an unhappy childhood in that she felt ‘different’ and had never fitted in and thus she had created an imaginary family in her imagination.

At the age of fifteen she was hospitalised legitimately for a neck injury. Two months later she presented in distress with severe abdominal pains. An appendectomy was performed but it was subsequently discovered that the appendix was normal. Thereafter she reported to various hospitals with complaints such as head injury, amnesia, nausea, vomiting and coughing. This patient also reported depressive and hypomanic episodes. She admitted to ‘conning’ the doctors in that at least five of her hospital admissions were factitious.

The patient had met the criteria for Anorexia Nervosa and Bulimia Nervosa from the age of fourteen until her mid twenties and had been hospitalised some eleven times for her eating disorder (Bulik, Sullivan, Fear, & Pickering, 1996). According to the writers, this patient “interwove symptoms of her eating disorder with a factitious presentation at times” (Bulik, Sullivan, Fear, & Pickering, 1996, p. 215). She had a distorted body image, an extreme fear of being overweight as well as amenorrhoea. Her eating disorder symptoms such as weight loss, vomiting and diarrhea were utilised to feign symptoms of medical illnesses and to gain hospital admission as part of the Factitious Disorder. Like Burge and Lacey’s (1992) patient discussed above, this patient was noted to seek hospitalisation in order to escape from her interpersonal difficulties. She also received attention and care from her family when she was ill. While not stated explicitly, the frequent admissions for different illnesses coupled with the fact that the patient sought admission suggest that the primary diagnosis in this case may be Factitious Disorder. In this case, the patient’s primary motivation appears to have been to assume the patient role.

In the third study, a twenty-six-year old patient being treated for Anorexia Nervosa in Japan was discovered to be fabricating her physical symptoms (Mizuta et al., 2000). This patient was raised in a suppressive family atmosphere where all her family members were very religious. She was seldom ‘cuddled’ and it was expected that as the eldest of three daughters she had to ‘control herself’. During her adolescence she rebelled against her environment and became preoccupied with dressing up, going out and loved drama.

However her rebellion stopped when she was in her second year of university when she became an ardent supporter of her parents' religion. At around this time she was hospitalised for Anorexia Nervosa.

This patient was hospitalised seven times for Anorexia Nervosa, initiated on her own request. During some of her admissions the staff had been suspicious about some of the patient's symptoms such as in the patient's sixth admission where a high fever occurred directly after a discharge plan was discussed. During the last hospitalisation, the patient had a high fever of unknown origin and was caught injecting unclean water into her intravenous bottle.

The writers of this study state that although Factitious Disorder appears different in manifestation to eating disorders, in terms of the underlying psychodynamics they may be quite similar (Mizuta et al., 2000). The role of deception in particular was highlighted in this study and was identified as being central to both Factitious Disorder and eating disorder patients. The writers accentuated that while there are similarities between the conditions, there are significant differences in that in eating disorders lying is aimed at denying symptoms whereas in Factitious Disorder, lying is utilised to exaggerate symptoms. It was emphasised that the following factors played a role in the patient's deception and Factitious Disorder:

- (i) "the patient had a lot of hate and aggression towards the therapist;
- (ii) there was much hate towards the patient's own body;
- (iii) there was an identification with the 'lying object'; and

(iv) the defence of splitting was utilised in order to maintain comfortable therapeutic relationships” (Mizuta et al, 2000).

This study also highlighted the difficulty in confronting patients with Factitious Disorder (Mizuta et al., 2000). This patient initially acted with rage when confronted and blamed the nursing staff for a “lack of consideration, incompetence, irresponsibility and insincerity and thereafter left treatment suddenly with no notice to the therapist” (Mizuta et al., 2000, p. 604).

The patient’s request to be and to remain hospitalised coupled with the inducing of illness (injecting water into her bottle to induce a fever) and her response to confrontation suggest that in this case Factitious Disorder may have been pre-eminent.

In all three of the above studies, the patients reported difficulties in early relationships with parents accompanied by estrangement from their families (Bulik, Sullivan, Fear, & Pickering, 1996; Burge & Lacey, 1992; Mizuta et al., 2000). The patients’ strong need for nurturance and affection emerged throughout these studies. In Burge and Lacey’s article (1992, p. 379), it was stated that hospitalisation allowed the patient “to satisfy her need for affection whilst remaining in control”. The patients all had had numerous hospitalisations for various reasons and the patients all sought hospitalisation. A critical reading of the studies suggests that in all of these cases the patients’ primary motivation was to *assume the patient role* and thus Factitious Disorder may have been pre-eminent.

2.4 The Psychodynamics of Anorexia Nervosa and Factitious Disorder:

2.4.1 Introduction:

Owing to the fact that this research is an attempt to understand the underlying psychodynamics that are present in a patient presenting with co-morbid Anorexia Nervosa and Factitious Disorder, the developmental theories of Mahler and Winnicott are discussed. Both these theorists are concerned with the processes of separation and individuation and it is argued that difficulties with separation and individuation are present in both the Factitious Disorder and the anorexic patient. Winnicott's theory of transitional objects will be explored since it is argued that in Factitious Disorder and Anorexia Nervosa the body is utilised as a transitional object. Masochism in the Factitious Disorder and the anorexic patient is then discussed.

2.4.2 Mahler:

Mahler's work was concerned with the processes of separation and individuation. Mahler (1968; Mahler, Pine, & Bergmann, 1975) states that this process comprises four stages; autistic, symbiotic, separation-individuation and on the way to object constancy. Mahler (1968) divides Freud's primary narcissism into two sub-phases:

- (i) absolute primary narcissism; what Mahler has termed "normal autism" relates to a phase where there is a lack of awareness of the mothering agent and where satisfaction of needs is the product of "hallucinatory wish fulfillment".
- (ii) In the symbiotic phase the infant gradually begins to perceive that his/her need satisfactions are coming from a need-satisfying part object, but still within an "undifferentiated orbit of symbiotic unity". According to Mahler, there must be

optimal human symbiosis for successful individuation and for a stable sense of identity to occur.

Mahler (1968) writes that thereafter a gradual process of “hatching” begins whereby the infant becomes aware of his/her own body and the environment. At the stage of around 10-16 months, there is a process of checking back to the mother, what Mahler has termed “customs inspection”. Mahler stresses the importance of the mother child relationship throughout the stages of symbiosis and of separation-individuation. She states that if the mother’s primary maternal function is unstable, anxiety ridden or hostile, this leads to disturbances in self-feeling and premature hatching or individuating.

According to Mahler (1968), during the separation-individuation stage, optimal psychological distance allows for “emotional refueling”. The mother needs to allow the child freedom and opportunity to explore while still allowing for the infant’s safety.

As Mahler states:

“ many mothers fail their fledgling, because they find it difficult to strike intuitively and naturally an optimal balance between giving support-and yet at the same time knowing when to just be available and to watch from a distance. In other words, for many mothers in our culture, it is by no means easy to give up smoothly their “symbiotic holding behaviour” –and instead to give the toddler optimal support on a higher emotional and verbal level” (Mahler , 1986, p. 211).

Mahler further states that during this process, returns to the mother may be associated with a fear of engulfment. During the *rapprochement* sub-phase of separation-individuation, the infant makes greater use of physical separation (Mahler, 1968). This is accompanied by active approach behaviour and concern with the mother’s whereabouts.

At this juncture, attempts at separation should also be expressed at a higher level of symbolisation. During the rapprochement phase, the infant gradually realises that love objects are separate and gives up his/her sense or delusion of grandeur.

It has been argued that a developmental failure along Mahler's continuum "results in an arrest in the differentiation of both the self and object representations and in their ego functions" (Masterson, 1977, p. 476). According to Masterson (1976), an arrest during the separation-individuation phase results in a splitting of the self and object representations. The ego defenses utilised are splitting, clinging, avoidance, denial, projection and acting out.

Masterson (1977) argues that most patients who have been diagnosed as having Anorexia Nervosa probably have a developmental arrest at the symbiotic or separation-individuation phase. Consequently "their principal problems revolve around fears of loss of self (engulfment) or fear of loss of the object (abandonment) as well as feelings of emptiness and struggles over autonomy" (Masterson, 1977, p. 476). Masterson states that the cause of the developmental arrest in the anorexic is analogous to the cause of the arrest in borderline patients. According to Masterson, the future anorexic's mother experiences the child's attempts to separate during separation-individuation, specifically the *rapprochement* subphase as threatening. She is unable to tolerate attempts that the child makes to separate and withdraws. In contrast, the child's regressive or clingy behaviour is rewarded.

Mahler and Kaplan (1977) argue that in both narcissistic and borderline personalities there is not a normal progression through the developmental process. While they agree that during the process of separation individuation there are sub-phase vulnerabilities that may lead to the development of a narcissistic or borderline personality organisation, they caution against over simplification:

“In our assessment of the personality organisation of narcissistic and borderline child and adult patients, the overriding dominance of one subphase distortion or fixation must not obscure the fact that there are always corrective or pathogenic influences from the other subphases to be considered” (Mahler and Kaplan, 1977, p. 84).

Thus in sum, Mahler’s (1968) theory stresses the importance of the early dyadic relationship. A developmental failure along Mahler’s continuum specifically at the separation-individuation phase results in a splitting of self and object relations. Masterson (1977) has argued that most patients who have been diagnosed as having Anorexia Nervosa have a developmental arrest at the symbiotic or separation-individuation phase. While Masterson has not written about Factitious Disorder patients, it will be argued that many of the difficulties, accentuated by the literature, that Factitious Disorder Patients experience in psychotherapy suggests that they may also have an underlying narcissistic or borderline personality organisation.

2.4.3 Winnicott:

Grolnick (1990, p.38) states that Winnicott’s major theoretical preoccupation revolves around the complex process of contact and separation. “He investigates the delicate and precarious nature of the dichotomies that face the individual struggling to achieve a sense of self while simultaneously investing in a meaningful relation to that which lies outside

of the self". Like Mahler, Winnicott (1956, 1971) emphasises the importance of the symbiotic relationship that exists between the mother and child. During the state of primary maternal preoccupation, there should be a state of acute sensitivity to the infant's needs. It is critical that there is a good enough adaptation to the needs of the infant. Winnicott argues that if there is not, the infant's sense of "going on being" is interrupted. In the symbiotic stages, maternal failures are threats to the existence of self.

Winnicott (1953) is concerned with the infants' differentiation from the "environment mother". In the beginning the infant cannot be understood as an independent entity but only in relation to the mother. The infant is unable to distinguish between inside and outside, everything is merged in a state of unintegration. Winnicott (1953, p. 91) uses the term transitional object to describe "an intermediate area of experience". His concern is with the first possession, the first not-me possession, also known as a transitional object, which symbolises the mother or the reunion with the mother (Winnicott, 1971). This object assists the infant to allay his/her fears and anxieties. According to Winnicott (1953), this object may be a bundle of wool, a corner of a blanket, a word, a tune or even a mannerism.

Winnicott (1953, p. 91) summarises some of the special qualities in the relationship:

- (i) "The infant assumes rights over the object,
- (ii) The object is affectionately cuddled as well as excitedly loved and mutilated,
- (iii) It must never change, unless changed by the infant,
- (iv) It must survive instinctual loving, and also hating,

- (v) It must seem to the infant to give warmth, have texture or to move,
- (vi) From the infant's perspective it does not come from within, nor is it a hallucination,
- (vii) Its fate is to be gradually allowed to be decathected".

A transitional object has great importance to the infant and is an "almost inseparable part" of the infant (Winnicott, 1953, p.92). Barkin (1978, p.514) emphasises that the transitional object is a bridge from maternal merger to relating to the mother as someone separate from the infant:

"While transitional relates to the object, it more specifically describes the infant that is in the transitional state to self and object representation differentiation, from symbiosis to separation and individuation, from part to whole object relating, traversing a path from narcissistic to object love".

While according to Winnicott, the body cannot function as a transitional object, Kafka (1969) expands Winnicott's theory of transitional objects and writes of a self-mutilating patient who utilised her body as a transitional object. According to Kafka (1969) in this patient the body acquired the function of a transitional object.

Following Winnicott, Gaddini and Gaddini (1970) emphasise the importance of 'good enough mothering'. Where mothering is deficient and where there is a breakdown of the holding environment, Gaddini and Gaddini argue that the child may fail to develop transitional objects. Deficient mothering includes situations where the mother is 'over-involved' with the baby, since this interferes with the "symbolisation of the reunion with the mother" (Gaddini & Gaddini, 1970, p. 347). The example of a mother who shared a

bed with her child is cited. In such circumstances the child is unable to “invent a transitional object” (Gaddini & Gaddini, 1970, p. 347). Such children may then utilise “*precursor objects*” in order to comfort themselves. Unlike transitional objects, precursors of transitional objects are those objects that have a capacity for comforting the child, but are given by the mother, or are part of the child or mother’s bodies.

Hirsch (1994) argues that Gaddini and Gaddini with their concept of precursors of the transitional object have resolved the question whether parts of the body that have soothing qualities could be defined as transitional objects. According to Hirsch (1994), in self-destructive acting out, the body is perceived as a transitional object and is handled as if it were non-living. Hirsch argues that self-destructive acting out aims to guard against threats of separation or an attachment-autonomy conflict and in such circumstances the body functions as a transitional object:

“Tensions arise by being alone, by threat of separation or actualisation of an attachment-autonomy conflict. For me is only a small step to assume that the body, which was made existing and available for the patient by means of self destruction, represents a maternal object providing protection against these threats” (Hirsch, 1994, p. 79).

In sum, Winnicott’s theories investigate the process of contact and separation. Winnicott’s (1953) term “transitional object” describes an “intermediate area of experience”. A transitional object is symbolic and represents the mother, or the reunion with the mother, and thus has great importance to the infant. According to Winnicott, the body does not function as a transitional object. However Kafka (1969) has written of a patient who utilised her body as a transitional object. Moreover, Gaddini and Gaddini (1970) have emphasised that where mothering is deficient or, to use Winnicott’s

terminology, not good enough, the child is unable to invent a transitional object (in terms of Winnicott's definition) and utilises "precursor objects". Precursor objects may include the body.

2.4.4 The Body as a Transitional Object in Factitious Disorder and in Anorexia Nervosa:

While there is literature on the use of the body as a transitional object in Anorexia Nervosa (Farrel, 1995; Boris, 1984), not much has been written about the use of the body as a transitional object in Factitious Disorder. Hirsch (1994) states that in Factitious Disorder, while the body is used as a transitional object there is a triangulation that occurs in that the doctors and the medical system become involved as external objects.

In terms of the anorexic's use of the body as a transitional object, Hirsch (1994, p. 78-79) states that when the anorexic is facing the development of her own body she panics since her body appears in "imminent danger of becoming as female as the mother's body". This represents an intolerable symbiotic threat to the anorexic who produces a non-female object within the body. The anorexic body protects the anorexic from being alone and thus provides the presence of a maternal object. Moreover the anorexic body protects against a bad object.

The root of this dynamic has been argued to be located in the anorexic mother's unavailability or over-involvement during the practicing sub-phase of the separation-individuation process as described by Mahler (Farrel, 1995; Masterson, 1977; Sugarman,

Quinlan & Devenis, 1981). There is a plethora of literature that describes the mothers of anorexics as controlling, domineering and cold as well as nagging and overprotective (Palazzoli, 1974; Sours, 1974). The exigency of the child lies in the fact that they are unable to strive for independence and autonomy without facing abandonment since the mother experiences difficulty in accepting the child's separateness. This impedes differentiation and leads to a situation of enmeshment (Palazzoli, 1978).

Sours (1974, p. 571) describes the anorexic's mother as follows:

“These patients have been attached to a domineering and controlling mother who attempts to attain passive submission and perfection for the child as her own fulfillment. Power and control exerted by the mother is overwhelming, remarkably interfering with separation and individuation in all phases of the child's development”.

It has been further noted by Sours (1974) that when one takes a history of an anorexic patient, certain patterns emerge. Typically these mothers idealise the developmental histories in that there is no mention of stranger or separation anxiety. No transitional objects are reported and the child's motility is described as having been difficult for the mother. Moreover, there is an over-emphasis on control and perfection.

This developmental arrest during separation-individuation leads to difficulties with object constancy. Meissner (1984) defines object constancy as the capacity to maintain a meaningful relationship to a specific object, whether one's subjective needs are being satisfied or not. Object constancy is inextricably linked to the capacity to use transitional objects. The anorexic patient is unable to use transitional objects since a stable internalised representation of the mother is absent. As Farrel states (Farrel, 1995, p. 50):

“Few eating disordered patients make it as far as using transitional objects. They remain fixed in the position of an intermediate object where the illusion of being safely held is exactly what is lacking and where a secure body image has not yet been achieved”.

A useful description is Boris' (1984) analogy of the anorexic as existing “without a skin”, in that others impact on the anorexic with “detonating force”. In order to resolve this, Boris argues that the anorexic creates an inner space that is “in me but not of me”. The anorexic “...sets all her soldiers of vigilance to monitor that space. Thus employed they do not have time or energy to notice the presence of the object who would otherwise excite desire and envy.” (Boris, 1984, p. 437).

Sugarman et al. (1981, p.51) state that for the anorexic patient,

“eating becomes the need gratifying activity which allows the patient to hold a sensory motor representation of the mother. Food is not the issue. Rather it is the activity of eating which is essential because the representation of the mother has not been differentiated from her need gratifying activity”.

They further argue that in the anorexic patient, there is an underlying anaclitic depression in that there is an emphasis on the immediate gratification of dependency needs.

Farrel (1995) suggests that in Anorexia Nervosa, the patient's mother may treat the child as a transitional object. This may mean that the mother creates a world where the child has to remain attached to the mother or else (in phantasy) her life is threatened. Farrel (1995, p.47) points out that while adults are meant to have progressed to art or literature as transitional objects, some women may have babies to “get in touch with a good internal object”. Rizzuto (1988) also implies that the anorexic may be treated as a

transitional object. In discussing the distorted communication that often exists in the anorexic's family she states that the child is discussed as if she were "a thing".

Thus in sum, in both Factitious Disorder and Anorexia Nervosa, the body may be utilised as a transitional object. In Factitious Disorder, in conjunction with utilising the body as a transitional object, the medical system may become involved as an external object. According to Hirsch (1994), the anorexic body acts as a transitional object by soothing the anorexic and protecting the anorexic from an anaclitic depression. It has been suggested by Rizzuto (1988) and Farrel (1995) that the anorexic's mother may utilise the anorexic-child as a transitional object.

2.4.5 Masochism in Factitious Disorder and in Anorexia Nervosa:

Both Spiro (1968) and Farrel (1995) have emphasised that in both Factitious Disorder and in Anorexia Nervosa there is a strong underlying dynamic of masochism. It appears that in both of these illnesses, a sense of mastery is achieved through the illness. It has been argued that individuals feel marked guilt in response to feelings such as anger or sexual excitation and that factitious or anorexic behaviour may be understood to some extent as a means of atonement or self-punishment.

Zerbe (1992, p. 178) writes that the sadomasochistic relationships that anorexic patients try to engender are a:

“repudiation of an early, faltering, highly destructive pre-oedipal tie to the mother. They reject any form of pleasure, particularly pleasure involving their own body. These patients refuse to make life choices or to mourn the losses of their childhood, and they avoid separation”.

Zerbe (1992) has further noted that masochistic trends are evident in the symptom itself. This is elucidated by the anorexic patient's restricting food intake or exercising excessively. Similarly in the Factitious Disorder patient's induction or simulation of illness or the invasive surgical procedures that they go through, masochism is present.

Berliner (1947, p. 460) writes that masochism is "the reenactment of submissive devotion to and a need for the love of a hating or rejecting love object". Berliner traces the origins of masochism to the early dyadic relationship and states that if the mother treats the infant with hate or ambivalence, the infant is placed in a precarious position. Due to the dependent infant's need for self-preservation and love the infant represses the perception since they cannot survive without the mother. Thus any hostile reaction is also repressed and the pain-giving object is then introjected. Thus Berliner (1947, p. 461) argues that masochism is the defense against the conflict between love and hostility and that suffering enhances the individual's sense of his value as a love-object:

"The deeper underlying motivation is the wish to please a hating parent, to placate or ingratiate himself with the parent by being unhappy, by failing, or by being helpless and stupid".

Thus in the symptoms of both Factitious Disorder and Anorexia Nervosa there appears to be an underlying masochistic component.

2.5 Psychotherapy of patients with Factitious Disorder and Anorexia Nervosa:

2.5.1 Introduction

There is a large body of literature that suggests that in both Factitious Disorder and Anorexia Nervosa there is an underlying personality disorder, particularly a narcissistic personality disorder (Feldman, 1995; Nadelson, 1979; Rizzuto, 1998; Spiro, 1968). The difficulties that patients suffering from both Anorexia Nervosa and from Factitious Disorder experience in psychotherapy appear to be indicative of this. Bromberg (1987) asserts that the cardinal feature of narcissism is a sense of unrelatedness. Bach (1977, p.209) describes therapy with these patients as being like

“talking into the wind or writing on the sand, only to have ones words effaced moments later by the waves. The patient either welcomes or resents the analyst’s words and frequently does not even register the content”.

Bach’s description of psychotherapy with such patients appears to be analogous to the Factitious Disorder patient and the Anorexic patient’s extreme sensitivity to interpretations that are made in therapy. For the Factitious Disorder patient, if interpretations are experienced as intrusive, confrontations are experienced as intolerable.

As discussed above, the literature illustrates that for both patients with Factitious Disorder and patients with Anorexia Nervosa, there is a problem with symbol formation. Ferenczi (1933, p. 59) argued that symbol formation and classical therapy was not possible for certain patients and thus certain modifications have to be made:

“I have found that for patients who are able to access their feelings, the process of free association is adequate, and those instances where they are not able to speak may be indicative of resistance. For others, including those whose disturbances are at the pre-verbal level, expressing feelings in words is not possible. The inability of these patients to speak is not a resistance, but is

due to their psychic trauma having occurred prior to the development of language.”

Following Ferenczi, Balint’s work emphasised mirroring, attunement and holding. Balint (1968) argues that there are certain characteristics at the level of the *basic fault*¹. These include that language is useless or misleading and interpretations are not “taken in” due to the fact that the ego is not sufficiently strong. The relationship at this level and all the events that happen in it belong to an exclusively two-person relationship.

Balint (1968, p.19) elaborates on the fact that interpretations are not taken in at the level of the basic fault:

“We give the patient an interpretation, clear, concise well founded and to the point, which often to our surprise, dismay, irritation or disappointment either has no effect on the patient or has an effect quite different from that intended”.

Interpretations at the level of the basic fault are experienced as persecutory and at this level words lose their meaning. Balint (1968, p.30) stressed the patient’s ability to “get under the therapist’s skin” and, if the therapist does not respond as the patient expects there are reactions and feelings of emptiness.

¹ Balint (1986) conceptualised three areas of the mind:

- (i) Area of the basic fault: Here the patient’s illness goes further and deeper than the oedipal conflict. Interpretations that are offered at this level may have no effect on the patient.
- (ii) Area of the oedipal level: At this level the patient and the analyst “confidently speak the same language”. While he acknowledges that a patient may reject an interpretation, “there is no question that it was an interpretation” (Balint, 1986, p.14).
- (iii) Area of creation

Thus far it has been argued that in both Factitious Disorder and in Anorexia Nervosa, the difficulties that these patient's exhibit within psychotherapy illustrate that the developmental arrest is at the *pre-verbal level*. This has implications for the role that the therapist needs to play. As Grolnick (1990, p. 67) states:

“When non-verbal needs must be met, too many words and too much meaning can preclude understanding. When higher level, developmental internalisations have taken place in a good enough manner, the holding operation moves to the verbal symbolic level”.

2.5.2 Factitious Disorder:

The treatment of patients suffering from Factitious Disorder is very difficult, and the prognosis is poor (Feldman, 1996; Nordemeyer, 1994; Plassmann, 1994). Plassmann (1994) outlines the difficulties inherent in working with patients suffering from Factitious Disorder as follows:

- (i) Difficulties in establishing rapport or a therapeutic relationship,
- (ii) Problems with confrontation, and
- (iii) Transference and counter-transference problems.

- (i) Difficulty in establishing a therapeutic relationship:

The fact that patients suffering from Factitious Disorder do not remain in psychotherapy long enough to establish rapport has been well documented (Eisendrath, 1989; Spiro, 1986). The difficulties that Factitious Disorder patients have in establishing a therapeutic relationship are indicative of the deep-seated problems that these patients have in forming relationships (Justus & Kreutziger, 1980). Moreover, the tenuous connection that is formed is very easily disrupted. According to Plassmann (1994), this is inextricably

linked to the problem of confrontation since once their illness is discovered, Factitious Disorder patients usually leave therapy or discharge themselves from hospital.

(ii) Confrontation:

The literature highlights the problem of confrontation of patients with Factitious Disorders. This is encapsulated by Plassmann (1994, p.9) who writes that confrontation

“ precipitates a sudden turn –about in the doctor-patient relationship, with a devaluation of the physician (and of the patient by the physician), accompanied by extremely high aggressive tensions in the relationship and the abrupt ending of the relationship”.

Hollender and Hersch (1970) emphasise the importance of confrontation with Factitious Disorder patients but state that the confrontation must be non-punitive and that the health care professional needs to understand the meaning of the patient’s behaviour. The writers argue that the patient’s behaviour should be understood as a distorted manner of communicating.

According to Feldman (1996), when patients with Factitious Disorder are confronted they they deny allegations, threaten malpractice actions or they flee. Eisendrath’s (1989), approach is to eliminate direct confrontation with patients. He notes that in his experience, direct confrontation was not successful and he emphasises the importance of the patient being able to ‘save face’ without being humiliated or rejected. Eisendrath utilises the strategies of inexact interpretations and the therapeutic use of double binds in order to assist the patient to ‘save face’.

Eisendrath (1989) highlights the importance of the defence for the Factitious Disorder patient in that the defence protects the patient. His technique is thus to give an interpretation that is “partially correct but incomplete” (Eisendrath, 1989, p.385). In this way the patient is able to make the therapeutic links when they are ready. In utilising therapeutic double binds, the patient is presented with the dilemma of the health professional in that the patient is told that they have received all possible treatment and that either the patient responds to the treatment or they will demonstrate that they have Factitious Disorder.

Other writers have emphasised the importance of a non-confrontational approach. Mayo and Haggerty (1984) argue that rather than confronting the patient, the therapist needs to be aware of the content of the patient’s metaphorical communications. Like Hollender and Hersch (1970), Mayo and Haggerty (1984, p.573) highlight that the factitious symptoms and fabrications should be understood as “metaphorical communications relating to the state of the patient’s current object relationships”. They argue that the patient with Factitious Disorder communicates through stories about family and friends and that while much of the communication may be incomprehensible as direct statements about real life, the patient will often provide a commentary on the state of psychotherapy. Moreover, the patient with Factitious Disorder utilises “meaningful fabrications” in order “to communicate fantasised wish gratification and the imagined expression of destructive impulses”. They argue that Factitious Disorders “may serve the purpose of maintaining an object relationship by splitting off threatening rageful impulses” (Mayo & Haggerty, 1984, p. 573) The challenge for the therapist is to maintain a steady interest in the patient.

While much of the literature emphasises the difficulty that Factitious Disorder patients have with confrontation, Mayo and Haggerty (1984) expand on this and discuss *the difficulty of the patient with Factitious Disorder in tolerating interpretations*. Such patients are unable to understand or to 'take in' interpretations and they thus argue that in therapy with patients with Factitious Disorder, the therapeutic interaction typically centers around narcissistic issues.

(iii) Counter-transference:

Feldman and Feldman (1995) note that Factitious Disorder patients tend to evoke counter-transference reactions in their therapists through the patient's overt behaviour as well as the patient's underlying emotional issues. The issue of deception is emphasised in the literature as being a particular stumbling block in the therapy of patients with Factitious Disorder. Feldman and Feldman (1995, p. 390) state that the deceit of the Factitious Disorder patient often induces "an immediate and potent sense of betrayal" in the therapist and that this may negatively impact upon the therapeutic process. However, if the therapist is aware of his/her counter transference this may assist the therapist in understanding the patient and rapport between the therapist and the patient may be deepened.

Feldman and Feldman (1995) further state that therapists need to be alerted to the following reactions to patients with Factitious Disorder:

- (i) Therapeutic nihilism, the belief that all patients with Factitious Disorder are untreatable,
- (ii) Anger and aversion as reactions to the factitious disorder patient,
- (iii) Breaches of confidentiality,
- (iv) Feelings of responsibility.

Eisendrath (1984) emphasises that the therapist or health care professional should not act out of anger and should be cautious of taking the patient's deception personally. Moreover, the masochism of the Factitious Disorder patient needs to be understood since the patient may attempt to get the therapist to play the role of a hostile or rejecting object.

Thus the treatment of Factitious Disorder patients presents many challenges to psychotherapists. Due to the Factitious Disorder patient's difficulty in forming relationships it may be difficult to form a therapeutic relationship. Once a relationship is formed, the relationship may be described as tenuous particularly due to the Factitious Disorder patient's acute sensitivity to rejection or criticism. For this reason, the Factitious Disorder patient is also unable to "take in" interpretations. If interpretations are experienced as difficult, confrontations are experienced by the Factitious Disorder patient as persecutory. Eisendrath (1989) has suggested that a means of circumventing the difficulties with confrontation is to provide the patient with a means of "saving face". Other writers have focussed on the need for a non-confrontational approach. Counter-transference difficulties have been accentuated in the literature and while the therapist's

reaction may initially present a stumbling block, they may also lead to a deeper understanding of the patient.

2.5.3 Anorexia Nervosa:

While confrontation is not highlighted as a particular problem in patients with Anorexia Nervosa, the literature on psychotherapy with patients suffering from Anorexia Nervosa highlights some similar features:

- (i) It is often difficult to establish rapport with them,
- (ii) The patient experiences difficulties with interpretation,
- (iii) there are transference and counter-transference difficulties:

- (i) Difficulties in establishing rapport or a therapeutic relationship:

As in Factitious Disorder, therapists often have difficulty in establishing rapport with anorexic patients. Farrel (1995) writes that the therapist's dilemma is how to make contact without triggering the patient's anxiety or flight. Since the anorexic may have spent her whole life avoiding being known or knowing people, it may be particularly difficult to establish rapport with an anorexic patient.

- (ii) Difficulties with interpretation:

Bruch (1978) highlighted the difficulties that anorexics have with concrete thinking and with symbolising. For this reason and due to the fact that anorexics found silences and interpretations intolerable, she was opposed to a strictly classical technique.

Sohn (1985) writes that interpretations often cannot be “taken in” by the anorexic patient in that there is an experience of interpretations as overwhelming or annihilatory. Rizzuto (1988) has documented the misunderstanding and confusion that anorexic patients demonstrate during psychotherapy. Rizzuto (1988, p.369) writes that anorexic patients “deal with the spoken word as though it is an indispensable but meaningless nuisance that they have no choice but to use”. Moreover, in psychotherapy there is often the experience of being “talked at” rather than being talked to.

Farrel (1995) argues that since the anorexic patient does not experience language as self-soothing, interpretations should be offered rather than being given dogmatically. With such patients, “a space has to be found where some reflection is possible for both the patient and the therapist” (Farrel, 1995, p.75). In order to facilitate this space, there has to be a “quiet tolerance of the muddle and uncertainty, of the gradualness of approximations, of error and apology that makes it possible for this patient to simply come to be” (Borris, 1984, p.441).

(iii) Transference and counter-transference difficulties:

Other writers have highlighted difficulties in the transference and counter-transference of treatment of anorexic patients. This is elucidated by Sohn (1985) who writes that powerful and primitive feelings are evoked in the therapist when treating patients with eating disorders. According to Sohn, bulimic patients evoke anorexic feelings in the therapist whereas anorexic patients may evoke bulimic feelings in the therapist. Farrell

(1995) notes that while these feelings are evoked, they are not so clear-cut in that an anorexic patient may evoke both anorexic and bulimic feelings in the therapist.

Palazzoli (1978) notes that it is often difficult when treating anorexic patients since intense feelings are stirred up in the therapist pertaining to the patient's making themselves ill. This dynamic can lead to feelings of resentment, anger or even hate in the therapist. As Farrel (1995, p. 60) states "*that a fellow human being should so damage herself and not want to be fed or recover is almost intolerable*".

Bruch's (1973, 1978) work also highlighted the anorexic and her parents' interdependency. She reported that since anorexics often lived out their parents' aspirations they are not able to discover their own needs. This dynamic of the patient trying to please the therapist may be recapitulated in psychotherapy. In Bruch's view (1978, p.12), psychotherapy should assist the anorexic "to learn of herself from herself". Thus the psychotherapist should facilitate this process and should guard against the expectations of the patient.

Another issue common to patients with Factitious Disorder that arises in therapy with anorexic patients is the patient's masochistic trends. According to Farrel (1995, p.72) within therapy, the patient often attempts to feel controlled by the therapist: "The aim of the patient is to be invaded, to feel controlling and so controlled, so that no separation is known or experienced".

The above illustrates that there are similarities in the treatment of Factitious Disorder and anorexic patients. It is often difficult for therapists to form a relationship with anorexic patients. Moreover, anorexic patients experience interpretations as difficult and there may be a poor understanding of interpretations. There are counter-transference difficulties in the treatment of anorexic patients and intense feelings may result concerning the patient making herself ill.

CHAPTER 3: METHODOLOGY

3.1 Introduction:

As outlined in Chapter 1, while the researcher was an intern psychologist at Tara's Eating Disorder Unit in Johannesburg, a patient was diagnosed as having co-morbid Factitious Disorder and Anorexia Nervosa. A literature search has demonstrated that co-morbid Factitious Disorder and Anorexia Nervosa is very rare and there is a paucity of literature on the subject.

The research will be undertaken in order to answer the following research questions:

- (i) What are the underlying psychodynamic factors in a patient with co-morbid Anorexia Nervosa and Factitious Disorder?
- (ii) What are the links between these diseases?

3.2 The Research Participant:

The patient, J, is a twenty-two year old woman who was admitted to the anorexic ward at Tara due to extreme weight loss. During the course of her admission, the patient was diagnosed as having co-morbid Factitious Disorder and Anorexia Nervosa. The researcher conducted the initial assessment and subsequent therapy in her capacity as an intern psychologist at Tara Hospital.

The patient signed a consent form agreeing to participate in the study and she was informed of her right to confidentiality and anonymity. She was informed that the findings of the research would be disseminated.

The researcher utilised only documents from the patient's file, there was no further contact between the researcher and the patient.

3.3 The Source Material:

The following documents were employed in order to answer the research questions:

- (i) A detailed case history,
- (ii) A detailed Psychological Assessment,
- (iii) Psychotherapy notes and transcripts.

(i) The Patient's Case History:

The patient's case history is a cardinal feature of the case-study method (Bromley, 1986). Key information from the patient J's history is presented at the beginning of the Results Section. This information is utilised to situate the research and to give an understanding of the patient's current situation (Edwards, 1998). The patient's complete Maudsley report appears in Appendix A.

(ii) A Detailed Psychological Assessment:

The Patient was assessed utilising the following tests:

- 1) The House-Tree-Person Test,
- 2) The Kinetic Family Drawing,
- 3) The Thematic Apperception Test.

The patient's Assessment report as well as her drawings and her TAT responses appear in Appendix B.

These tests are all projective tests. The projective hypothesis assumes that the individual's fears, needs, defenses and coping mechanisms will be reflected in his/her responses (Groth-Marnat, 1997).

1) The House-Tree-Person Test:

According to Hammer (1958), individuals express in drawings "quite unwittingly (and at times unwillingly) their view of themselves as they are, or would like to be". Moreover, Hammer argues that the person's perceptions of the environment are present in the drawing.

The House-Tree-Person test is administered by asking the testee to first draw a house. When this is completed the testee is asked to draw a tree and finally, the testee is asked to draw a person. Buck (1958) originally developed the test. It has been argued that the strength of the test as a projective test is that the items are familiar to all and are usually easily accepted. Moreover Buck (1958) ascertained that the test stimulated verbalisation.

The drawing of the house enables the testee to express attitudes and relationships within the family and the home while the tree and person test reflect the body image and the self-concept of the person.

2) The Kinetic Family Drawing:

The Kinetic Family Drawing is administered by asking the testee to draw a picture of their family “doing something”. This picture also enables the patient to express family dynamics and relationships.

3) The Thematic Apperception Test (TAT):

The TAT was first described by Morgan & Murray (1935), and further developed in 1938 and 1943 (Morgan, 1995 in Groth-Marnat, 1997). The TAT is administered by asking the testee to tell a story in response to ten pictures. The instructions for administration are as follows:

“ This is a test of imagination, one form of intelligence. I am going to show you some pictures, one at a time and your task will be to make up as dramatic a story as you can for each. Tell what has led up to the event shown in the picture, describe what is happening at the moment, what the characters are feeling and thinking; and then give the outcome. Speak your thoughts as they come to your mind. Do you understand? Since you have 50 minutes for 10 pictures you can devote about five minutes to each story. Here is the first picture” (Bellak, 1963, p43).

Bellak (1963) argues that the TAT investigates the dynamics of personality specifically within the context of interpersonal relations. Moreover, the TAT cards elicit the individual’s perception of the environment.

(iii) Psychotherapy Notes and Transcripts:

Selected excerpts from the patient’s therapy will be discussed. Due to the confidential nature of the psychotherapy, the researcher’s therapy notes and transcripts do not appear in the Appendices of this thesis.

3.4 Data Processing and Interpretation:

The proposed research is grounded within a broadly qualitative paradigm that involves examining the meaning of people's words and actions. (Maykut & Morehouse, 1994) According to Bromley (1986, p.39), the case-study method is the "bedrock of scientific investigation". Bromley (1986, p.5) argues that the "careful observation, description and comparative discussion of individual cases" is the foundation of clinical knowledge. The single case-study method is utilised as it has been proven to be particularly valuable in the field of clinical psychology since this method enables the researcher to glean an in-depth and thorough understanding of a patient. According to Yin, (1994) this has commonly been the situation in psychology in that a specific disorder may be so rare that any single case is worth documenting and analysing.

Bromley (1986, p.6) states that a psychological case-study is "a study of a person in a situation". A case-study presents the researcher with a close view of a significant event within a person's life and enables the researcher to analyse and interpret this event. According to Bromley there is no standard way of conducting case-study research. A case-study is selective in that it addresses some issues and ignores others. Bromley argues that the intensive study of individuals leads to a deeper understanding and thus may be utilised as a basis for theory building. The aim of a quasi-judicial case-study is to "formulate a cogent argument" or a theory or explanation about a person's adjustment.

Edwards (1998, p.40) has identified six assumptions underlying case-based approaches.

1. “The ultimate task of science is not to map human behaviour and experience on a vast matrix of variables from which predictions can be determined”. Edwards elaborates on this and cites the example of factor analytic models and it is argued that such models have a limited relationship to “real psychological and interpersonal processes”.
2. It is argued that quantification is not “an end in itself” and that the problem with quantification is that the individual is lost in the scores.
3. The quality of the data in qualitative data is rich and yields a plethora of information.
4. Participants in case-based research are viewed “as persons and treated as individuals”.
5. Sufficient data is collected to “enable meaningful relationships to be examined within a single case”.
6. Research material may be used as a basis for theory development.

According to Edwards (1998), the first step in case-study research is to develop an in depth and accurate description of particular cases. Once this is achieved, the second step is to conceptualise the case material in psychological terms. Edwards notes that the case-study method depends on working with a series of cases, although a researcher may only work in depth with only one case. Information from a single case study method may become a general principle once the research is confirmed by other cases. Maykut and Morehouse (1994), refer to a purpose of qualitative research as being “*interpretive-descriptive*” in that the data is accurately described in a manner that the researcher has

understood and since some of the interpretations are found in descriptive research, suggest an interest in theory building. Yin (1994) has referred to this process as “*explanation-building*”. The purpose of the proposed study is to analyse the case-study data by building an explanation about the case that will contribute towards the development of theory into the psychodynamics of co-morbid Anorexia Nervosa and Factitious Disorder.

In doing so, key themes were drawn from the patient’s history, the assessment material and from the psychotherapy notes and transcripts. These themes are analysed and discussed. Due to the plethora of information in this case, only themes that have emerged as predominant are discussed.

CHAPTER 4: RESULTS

This section is divided into three sub-sections:

- (i) Synthesis of the Patient's History,
- (ii) The Assessment,
- (iii) Therapy

The Synthesis of the Patient's History is intended to orient the reader and to present important information from the patient's history. In the remaining two sections, central themes are drawn out.

4.1 Synthesis of the Patient's History

J is a twenty-two year old, third year Bachelor of Commerce student at the Rand Afrikaans University (RAU). She was admitted to the anorexic ward at Tara in August 2001 due to extreme weight loss and her restrictive eating pattern. At the time of the admission, J weighed 48,2 kgs and was 13,7% underweight.

Relevant Family History:

J is the oldest child and only daughter in a conservative and religious family. J and her mother have a very close relationship and are "more like sisters" than mother and daughter. J feels ambivalent about her mother in that she oscillates between having negative feelings towards her mother and "needing her". She feels that she needs to find "space" from her mother but she is unable to verbalise this. J's mother suffers from depression.

J's family has always been very involved with their church. J reported that when she first became anorexic in 1995 her grandmother had informed her that anorexia was "from the devil". J's parents attributed her recovery from anorexia in 1995 to events that took place in their church.

J's description of her brother and father did not convey a sense of relatedness between them. However she did demonstrate some insight, albeit limited, into her family functioning and its bearing on her current difficulties. Moreover she was able to make some connections between her past and present functioning.

Relationships:

Apart from her family, J does not have any close relationships. J attributes her lack of friendships to the fact that she has always been so ill and she has often been in hospital while people her age have been engaged in "normal activities". While J has a deep yearning for relationships with others she complained that she is "unable to connect" with people. The lack of relationships leave J feeling isolated and detached from others.

Self-concept:

J does not have a continuous sense of herself as a person. She was unable to describe herself and she often said that she didn't know what she was thinking or feeling. Linked to this she frequently compared herself to others. In therapy J often spoke of feeling "cut

off' and "behind a screen". Linked to J's poor sense of self, she finds it difficult to integrate any ambivalent feelings that she has.

Medical and Psychiatric History:

In July 1995 J was admitted to Tara Hospital for Anorexia Nervosa. At the time of her first admission she was 31% underweight. In December 1995 she refused hospital treatment and her parents agreed to take her home. In 1996, J was able to complete her Std 9 and matric in one year. Due to her "focus" on her academic work she was able to "forget about her anorexia" to some extent.

In 1997, J became ill with recurrent bladder infections, interstitial cystitis. During 1997 she was admitted to the Milpark and Garden City Clinics for treatment of the bladder. At this juncture she was treated with DMSO, Heparin and cystoscopies. In June 1999 she had an augmentation cystoplasty and then a YV plasty of her bladder neck. In March 2000 she had a total cystectomy with a small bowel orthotopic bladder replacement. Following this operation she had an obstruction in the bowel and she was rushed back into theatre. It was reported that when J came around she was paralysed for about two months. In November 2000, J was readmitted to hospital with septicemia.

J has recently been diagnosed with Crohn's disease. She reported that her urinary tract difficulties and her difficulties catheterising herself in tandem with the Crohn's disease exacerbated her anorexia. She elaborated on this and said that she would rather not eat since when she ate she would have to catheterise herself more regularly.

J reported that in 1997 she had had three grande mal epileptic seizures. Her father stated that while there had been a “loss of consciousness” there had been a query as to whether the seizures were grande mal seizures.

4.2 The Assessment

4.2.1 J’s relationship with her mother:

Throughout the assessment, J’s relationship with her mother emerged as a major theme. In the Kinetic Family Drawing J drew her family on the beach on holiday. J and her mother are standing together underneath an umbrella. Her father and her brother are engaged in their own pursuits; her father is “going off to talk to someone” and her brother is swimming. The drawing highlighted the fact that J and her mother have a very close relationship, however, the posture and the closeness of the figures suggest that there may be inappropriate boundaries between them. While the figures are depicted as being close together, there does not appear to be a good connection between them. Both J and her mother have marked unmet dependency needs. J appears to be making a tentative attempt to leave her mother, in that her legs are facing another direction but she appears unable to leave.

Linked to this, in J’s picture of her house, she is pictured looking out of a window but the numerous bars on the window suggest that she is unable to leave. While she was drawing this drawing she stated that she was “looking out of the window”. This response suggests

that while she wishes to escape from the confines of her family there may be a lack of engagement with an extended community.

In the Thematic Apperception Test, J's responses further conveyed that her relationship with her mother is an enmeshed one and that there appears to be much guilt surrounding this relationship.

Card 2

"This picture, the mother is very strict. The girl with the books is very innocent. The mother keeps a careful eye on her. The man in the background is carefree... He just has to look after the horses whereas she has to go to school and has to be the ideal person. The son can look after the horses and that but she, she has to.... The mother is expecting another baby. I think the girl seems to be alone, on her own. I think the girl wishes that she was in the guy's position, there doesn't seem to be a father around. The guy takes care of all the manly duties. The way it ends up is the young girl is doing things to the mother's expectations. She's there for the mother through it all. The son, well he just does his own thing. And that is all I can think of."

This response clearly conveys J's wish to separate from her mother however she feels that she is unable to do so and she ends up doing things "to her mother's expectations". While J wishes to separate from her mother she also feels somewhat isolated from her. The words "alone" and "on her own" emphasise this. The mother is depicted as

somewhat harsh and punitive and the response suggests that J fears the consequences of separating from the mother.

In another response, (Card 5), this dynamic is also outlined. In this response the girl attempts to exercise and she and her mother have a “massive argument”. As a result of the argument, the girl feels guilty about exercising but despite her promises she is unable to stop exercising and a cycle of guilt ensues. This response further accentuates J’s difficulty in dealing with conflict with her mother. She experiences conflict as intolerable in that she feels that she is “unable to help herself” and the situation ends up as “uncontrollable”.

J’s responses convey that she believes that she has to meet her mother’s needs and expectations:

Card 7GF

“She and her mother are very close to each other. So close. She might not be wanting to hear what her mother is saying, the way her head is turned. She’s sitting there to please her mother and she does what her mother wants. She seems to be holding on to the doll for safety. I think she’s going to put up a performance and storm off and her mother’s going to get upset and wonder why...”

This response also conveys that J feels unable to effectively express her needs to her mother. Her mother is perceived as being unable to contain her anxiety and thus J feels the need to hold on to a doll for safety.

4.2.2 High Parental Expectations:

The theme of having to meet others' expectations, specifically parental expectations was evident in another response:

Card 1

"This boy, maybe like his parents are pushing him to play the violin. He doesn't want to play it. He's miserable. He had a fight with them and he's been pushed and he doesn't enjoy it. Or, he's let them down in some way. He could have been interested in the beginning but now, because he's been pushed so hard, he hates the violin. He did enjoy it when he started out. Eventually he stops. That's all".

The response suggests that in the face of what is perceived as unobtainable pressures and expectations, J believes that she is unable to continue and that she is bound to fail.

4.2.3 Overidentification with the patient role:

It appears that when J feels overwhelmed or anxious, she may resort to the patient role in order to cope. This was a common theme in J's responses suggesting an over-identification with the patient role. The following excerpt illustrates this:

Card 3BM

“Something really bad has happened to her. Things have been building up for a while, and now she’s lost control. She’s crying her heart out. She can’t handle it anymore. She feels hopeless and tired. She’s tired of everything. She wants to give up. The way I see it she ends up in hospital having a nervous breakdown or committing suicide. She lands up in hospital. She is hospitalised.”

This response demonstrates that J is unable to self-soothe and that she has a poor sense of object constancy. Her stories convey that when she feels overwhelmed, she seeks out hospitalisation as a form of containment. The following response further emphasises that hospitalisation may be a form of containment for J. This response also highlights the extent of J’s feelings of being overwhelmed and feeling unable to cope.

Moreover other responses suggest that J may adopt the patient role in order to cope with her feelings of alienation or loneliness. The theme of estrangement or dissociation was present in both the patient’s drawings as well as the TAT responses. A projective analysis of the drawings of the person, the house as well as the tree indicates that J feels ungrounded and unsupported by the environment. In the Draw-A-Person drawing the mask like quality of the face in tandem with the stilted quality of the figure further highlights a sense of withdrawal from others and that she adopts a façade in order to cope with the demands of her life.

In the TAT responses, the repetition of certain words such as “alone” or “all alone” highlight a sense of loneliness. Moreover there appears to be a lack of connection between the persons in the responses in that there is very little communication and the communication that exists appears somewhat tense and strained. The following response elucidates the patient’s sense of loneliness and suggests that through hospitalisation J’s acute dependency needs are met to some extent:

Card 8GF

“The lady is deep in thought. She could be thinking of something that has just happened. She is keeping all her feelings bottled up inside her. She doesn’t know where to go. She’s not getting support from anyone around her. She’s lonely and I think the way it would end is she’s going to lose control. She doesn’t speak out or say what is on her mind. She loses control or she seeks help. She, her problems do get solved and on the other hand she could maybe have a break down. She looks innocent but when the anger’s out she can be aggressive. Maybe she’ll go to hospital.”

J’s responses further convey that she believes that through illness she will attain perfection in her relationships with others.

Card 13MF

“An old man, he’s by his wife’s side. She has had cancer or some other terminal illness. They really loved each other. He stuck by her. She was a good person but she passed away and so he is crying. Maybe he is crying

because he knows that she is at peace. She does not have to suffer anymore. He has lost his partner, he will miss her.”

Thus this response idealises illness. Moreover, this response further conveys a masochistic dynamic in that this response suggests that suffering enhances the individual's sense of value as a love-object.

4.2.4 The Body:

In both the Kinetic Family Drawing and in the Draw- A- Person, the theme of a distorted body image emerged. J is an emaciated young woman, yet she depicted herself as a “fat and ugly” person in the Draw -A -Person test. In the Kinetic Family Drawing, all of the bodies particularly her own are distorted and with the exception of her brother, they are “fat”. J has emphasised her brother's athletic body drawing attention to his muscles.

The theme of preoccupation with the body was evident in one of the TAT responses where J spoke of excessive exercise. However the responses conveyed more a concern about the body with regard to illnesses and hospitalisation rather than a concern about weight and body shape.

4.3 Therapy:

4.3.1 The Process

4.3.1.1 Difficulty In Establishing Rapport

J quickly formed an intense relationship with the therapist. During her first few weeks at Tara she would typically arrive early for her therapy sessions and at the end of her sessions she would display a reluctance to leave. The therapist found it difficult to stick to the time-frame with this patient due to the patient's neediness but also due to the fact that the patient was an in-patient and during the day she would typically invent numerous excuses to enter the therapist's office. She would also walk past the therapist's office on occasion. Thus the therapist experienced J as being intrusive. After some reflection it became clear that J was communicating a pattern of relating to others.

Throughout J's stay at Tara, but particularly initially, *she demonstrated an intense need for mirroring*. She demonstrated this through asking numerous questions about how the therapist perceived her. Moreover she talked about her relationships with people and her sense of aloneness and how she longed for a feeling of closeness or merger. While the patient expressed an intense need for mirroring and appeared to become very dependent on the therapist, the therapist found it difficult to engage with J. J's speech in therapy sessions typically gave the impression of her talking to herself. During this time she gave endless recitals and litanies about the girls on the ward as well as her parents. She often complained that life was a "waste" or that she "might as well end it all".

The therapist's main interventions at this juncture were an attempt to establish rapport with the patient and to try to understand what the patient was feeling and communicating. But at the beginning of therapy, anything that the therapist said was rejected or ignored. The therapist's counter-transference was to feel confused since the patient appeared to be giving contradictory messages. On the one hand she appeared to be expressing her extreme dependency and neediness yet at the same time there appeared to be a sense of unrelatedness. This contradiction was understood by the therapist as the patient's attempt to communicate her exigency. While the patient wished for mirroring and an intensely symbiotic relationship, she was communicating her fear of intrusion and her fear that relationships represent the danger of engulfment.

At the same time *the therapist experienced therapy as fragmented* in that there was no apparent connection between therapy sessions. There was a disjointed feel to the therapy in that J would profess to have no memory of the previous session (sometimes only two days previously). When the therapist attempted to remind her, this was often met by silence. This lack of connection between the therapy sessions could be understood as the patient's fragmentation.

The lack of connection between therapy sessions was compounded by the *patient's poor sense of self*. Often the patient found it difficult to access her feelings and she complained that she did not know what she was thinking or feeling and her thoughts changed frequently. The patient also frequently compared herself to the other anorexic patients. Thus the therapist's aim was to try to put the patient in touch with her feelings.

Gradually a therapeutic alliance was established and the therapist began to feel that she was more 'in tune' with the patient. The therapist still experienced the patient as intrusive and as a working alliance began to be developed, the patient sought the therapist out more and more. At this juncture the patient began to leave notes for the therapist between sessions and appeared to become more intrusive. It was sometimes difficult for the therapist to insist on the therapeutic frame. However once the therapist became clearer with her own boundaries it was observed that the patient appeared less inclined to test the limits of the therapeutic space. The patient also communicated that she felt more contained by the therapist and made comments about the therapeutic space.

The patient still remained acutely sensitive to the therapist's gestures and interpretations.

Throughout the therapy, it was difficult for the patient to accept or utilise the therapist's interpretations. When the therapist was dogmatic in the offering of an interpretation or said too much too soon, the patient would physically block the therapist out with her body in that she would turn away from the therapist. On one occasion she touched her ears with her hands. On other occasions it appeared that the therapist's interpretations had no effect on the patient in that she carried on talking without any reference to the therapist.

4.3.1.2 The Dilemma of Confrontation:

The dilemma of confrontation remained a difficult issue for both the therapist and the staff, since during the course of J's stay, a number of anomalies became apparent. When

presented with the apparent contradiction between J's symptoms and her behaviour, the staff and therapist had to decide on a course of action:

During the course of J's stay at Tara she complained of depression and of feelings of suicidality. Initially the therapist and all of the Tara staff were very concerned and J was placed under special observation for a period of some two weeks. During this time the nurses noted that there was a disparity between J's behavior when she thought that she was being observed and when she thought that she was alone in that she appeared to put on an act. Moreover her behavior was not consistent with the "despair" that she complained about. In therapy the therapist also became aware of these contradictions. Increasingly the therapist wondered if J would complain that she was suicidal in order to convince the therapist to see her for extra sessions but the content of the therapy sessions were not consistent with the feelings she reported.

The therapeutic team informed J that they had to consider placing her in a lock-up more secure ward to provide her with greater containment. Within a few hours of being informed of this, J informed the nursing staff that she was "much better" and that the depression "had lifted".

Thereafter J had a number of seizures. During these times she was observed by the nursing staff to have been "very out of it". After these seizures J complained that she was epileptic. The nursing staff were concerned about J but were skeptical about the patient's diagnosis of epilepsy. During one of the ward rounds a nurse commented that during the

seizures J appeared to be “drugged out”. There had been reports from other patients that J had been seen taking pills prior to these seizures. J’s mother was then seen giving J pills during one of her visits to Tara and J was confronted by the nursing staff about taking pills prior to the seizures. Her response was to angrily deny that she had taken the pills. Thereafter she became very tearful and withdrawn. Her immediate response was to express the desire to leave Tara immediately and she tried to persuade her parents that she should leave.

The issue of confrontation raised some further counter-transference issues for the therapist. When the contradictions between J’s behavior and symptoms had first become apparent the therapist had been reluctant to acknowledge the contradictions. The therapist had been convinced that J had had one misfortune after another and was thus reluctant to engage with the possibility that she might have been the author of these situations. However, as the contradictions built up and since the therapist noted some of the contradictions in therapy, the therapist became somewhat skeptical of the patient. It was highlighted above that the patient was acutely aware of the therapist’s non-verbal and verbal gestures and thus despite the therapist’s attempts to keep any negative feelings away from the therapy space, the patient could detect the subtle differences in the therapist’s attitude. While the rapport between the therapist and J had deepened considerably since the beginning of therapy, the therapeutic alliance was a tenuous one and once J detected the therapist’s skepticism she withdrew from therapy to some extent.

When it became evident that J had taken pills to induce 'epilepsy' the suspicions of the nursing staff were confirmed and the two of the nursing staff confronted J. The effects of this confrontation permeated J's therapy sessions. J arrived for her first session after her confrontation with the nursing staff very quiet and withdrawn. She sat in the session with her head bowed and she refused to make eye contact with the therapist. When the therapist gently asked her what was wrong she accused the therapist of believing the nurses rather than her. She informed the therapist that she was leaving and that she "hated Tara".

It must be noted that at this juncture to some extent the therapist had felt somewhat betrayed by the patient. She felt that the time and energy that had been spent on therapy sessions had been a waste of time. Thus J may have picked up on this and hence her angry accusation that therapist had believed the nurses rather than her.

4.3.2 The Content

4.3.2.1 J's relationship with her mother.

In therapy J frequently discussed her relationship with her mother. Initially J struggled with the separation from her mother. Her mother and father deliberately admitted J to Tara prior to going down to Cape Town to visit friends. This was since J's mother felt that if she was in Johannesburg she would visit J too often or she may have been persuaded by J to have her discharged. Thus in her first therapy sessions J talked about her mother's physical absence from Johannesburg and her concomitant feelings about this. It was difficult for J to discuss her varying feelings about her mother and she

oscillated between expressing her anger and denying her anger to experiencing guilt about her feelings. J's ambivalent feelings thus often resulted in a disjointed feeling from session to session.

Excerpt: Therapy Session 1

J: I just can't believe she would go this week. Of all the times to go. I'm here and she's there.

Therapist: It seems very hard at the moment that your mother's away and this is your first week in Tara. You really need her right now.

J: It makes it worse that she's not here. Why did she go? She should have stayed. (J clenches her fists)

Therapist: I'm wondering if you're feeling angry with your mother.

J: It's selfish of her to go right now. How could she go? I'm not angry. I wouldn't say I am angry with her I mean they do have to go....

But why now?

Therapist: It seems that you're angry but you don't think you should be angry?

Silence

J: I don't know what I am thinking half the time. They must be pleased to have me safely here. I hate it here. I hate the place. It's cold and the bathrooms are dirty. The food isn't nice. I really don't like the other girls and they don't wash out the baths.

Excerpt: Therapy session 2

Therapist: Hi J

J: Hi (looks down, avoids eye contact).

Silence

Therapist: Sometimes it's hard to get started.

J: I just can't remember anything about the last session at all.

Therapist: I think you were talking about being here. It's hard to be here and you were missing your mother. You were also feeling a little angry with her.

J: Oh yes, (pauses) I still can't believe I was feeling that. I've been feeling really bad about that. Really, really bad.

J struggled to acknowledge any negative feelings that she had towards her mother. She experienced her negative feelings as somewhat overwhelming. Towards the end of her stay at Tara J dealt with her feelings about going home and not having any space from her mother. She spoke about how she wished to separate from her mother but she felt powerless to do so. During therapy she gave some examples of her mother's involvement in her life. The following excerpt illustrates this:

Excerpt: Therapy Session 22

J: It's like she's always there.

Therapist: Mmmm

J: I can't get away. She's always in my room. She watches me when I bath. She decides what I eat. Do you know that I have never been allowed to get my own food? She decides. We've had fights about this where I've said I'd really like to make a salad and she's said "no". Okay sometimes I've actually been allowed to do it, I mean make food but then she's there. And she uses the excuse that I'm anorexic but these are at times where I haven't been anorexic; where I haven't had any problem with food. It's her problem not my problem!

(Patient raises her voice, and speaks very quickly).

Therapist: It feels very difficult to have no space of your own.

J: Yes. It makes me feel very angry. Very, very angry. (Clenches her fists). I don't know what to do about this. I spend my life trying to make them happy.

At the following session, J was unable to acknowledge any of these powerful feelings and focused on her parent's visit the previous evening. When the therapist attempted to remind her of the previous session she became silent and turned her body away from the therapist. She later placed a note under the therapist's door wherein she apologised for her behaviour during therapy.

4.3.2.2 Over-identification with the patient role:

Much of J's anxiety centered around her fear of being discharged. She emphasised that she was not "as thin" as some of the other girls and thus she might be sent home early. What was interesting about J's discussions about weight gain was that she appeared to be anxious about being discharged rather than about gaining weight. The increase in her weight did not appear to alarm her to a significant extent, rather when she gained weight she would list her "many problems" and she would ask the therapist when she was likely to be discharged. While initially J had expressed her dislike of the unit, over a period of time, J admitted that she felt increasingly comfortable in the unit and asked for her time at Tara to be extended. It also emerged that J had suggested that she be placed in Tara to her parents and her therapist. The following excerpt demonstrates J's identification with the patient role and her wish to remain a patient.

Excerpt: Therapy Session 15

Beginning of a session:

J: Jeanne, I've been wanting to talk to you about something for a while.

Therapist: What's bothering you?

J: When will I be discharged?

Therapist: The date's in your file. I'll have to check it.

J: I know. It's just that I don't feel ready to go.

Therapist: There's still quite a lot of time.

J: It's just that I've been dealing with so much.

Therapist: You'd really like some more time. You know that it's not just up to me and it will have to be discussed with the whole team.

J: I'm not ready to leave. I really want to stay here.

4.3.2.3 The Body:

J discussed her body in psychotherapy frequently. She described the different surgical procedures and frequently emphasised the fact that she was suffering from severe pain. The content of most of the therapy sessions focussed on J's body and her experience of being ill. J's weight gain on the anorexic diet was erratic in that she gained weight in some weeks but in other weeks she lost weight. She blamed this on Crohn's disease and the fact that she had diarrhea. J described her body as being a "safety net" and she said that she often "felt her wrists". Similarly she said that she used to touch her scars from her operation compulsively. The following excerpt demonstrates J's description of her body as a "safety net":

Excerpt: Therapy Session 16

Therapist: Celeste tells me that you're feeling anxious about your weight gain?

J: Mmm (Starts feeling her arms). Avoids eye contact. It is really difficult.

Therapist: It is hard to eat?

J: My body is not as thin as the other girls. I look at them and realise that I'm not thin. I'm not thin like I was the last time I was here. I will show

you a photograph I have one in the ward. I know what you are going to say!

Therapist: Mmmmm

J: That I'm comparing myself to everyone else again.

Therapist: Are you?

J: I guess so... It is hard for me because you are taking my safety net away from me.

Therapist: You feel that your body is a safety net for you.

J: My bones are like that. Right now I can feel them.

Therapist: You told me that you also feel your scars.

J: (nods)

Silence.

CHAPTER 5: DISCUSSION

The predominant themes that emerged from the results of the assessment and therapy sessions were difficulties in the patient's relationship with her mother, estrangement or dissociation, over-identification with the patient role and a disturbed sense of the body. In therapy the patient's acute sensitivity to the therapist's gestures made it difficult to establish rapport with her. Moreover she was particularly sensitive to interpretations in therapy and found them to be intrusive. If interpretations could be described as intrusive, this patient experienced confrontation as catastrophic, and as representing a threat of annihilation to her.

These themes are discussed in this section within three sub-sections:

- (i) A comparison between this study and the other studies,
- (ii) The content of the assessment and the therapy sessions,
- (iii) The process of the therapy sessions

5.1 A Comparison between this study and the other studies:

All three of the studies on co-morbid Anorexia Nervosa and Factitious Disorder emphasised the fact that the conditions occurred concomitantly. Burge and Lacey (1992) argued that in the case of their patient, the Anorexia Nervosa was pre-eminent in that the Factitious Disorder was utilised as an "emotional defense" in an eating disorder and that the patient attempted to avoid anorexic feelings. While this is the case, this writer has argued that in all three studies, the Factitious Disorder may actually have been pre-eminent:

In the Burge and Lacey study (1992) the patient's numerous hospitalisations coupled with her need to assume the patient role attest to the fact that this patient's primary diagnosis may have been Factitious Disorder. In the study of Bullik and colleagues (Bullik, Sullivan, Fear & Pickering, 1995, p.216) the patient was frank about "conning the doctors" and she admitted that at least five of her hospitalisations had been factitious. Like the patients in these two studies, J also appears to have had numerous hospitalisations and there appears to be *an over-identification with the patient role*. Burge and Lacey (1992, p.380) stated that the patient in their study "would rather spend a weekend in hospital than a weekend with friends". This is also the case with J in that through hospitalisation her acute dependency needs are met to some extent.

The patient in the Mizuta study (Mizuta et al., 2000), also appears to have demonstrated an over-identification with the patient role. Like the patient in the Mizuta study J had been hospitalised numerous times on her own request. Throughout the Mizuta patient's hospitalisations there had been suspicious episodes such as the sixth admission where the patient developed a fever after a discharge plan was discussed. Similarly, in the case of J there were also suspicious episodes that occurred. Moreover, J appeared preoccupied with her discharge date and she sought to persuade the clinical team that due to the complexity of her problems, she was not ready to be discharged.

In the Mizuta study (Mizuta et al., 2000), the role of deception was highlighted as being central to an understanding of both Factitious Disorder and Anorexia Nervosa. The

writers state that in Factitious Disorder symptoms are exaggerated whereas in Anorexia Nervosa symptoms are minimised. The patient in the Mizuta study exaggerated her symptoms in order to remain a patient. Similarly, J exaggerated her symptoms and attempted to convince the therapeutic team of the severity of her illnesses. This may be an important difference between Factitious Disorder and Anorexia Nervosa and may assist clinicians in the difficult task of making a diagnosis.

Moreover, the patient in the Mizuta study (Mizuta et al., 2000) demonstrated *difficulties with confrontation*. After she was confronted about injecting water into her bottle she responded with anger and thereafter left treatment suddenly. J demonstrated this same pattern in that she was angry and upset when confronted and she was discharged shortly thereafter. This response to confrontation dovetails with the literature on Factitious Disorders (Eisendrath, 1989; Feldman, 1996; Justus & Kreutziger, 1980) and further suggests that in the Mizuta study, the diagnosis of Factitious Disorder may have been the primary diagnosis.

Thus in sum, there are similarities between J and the patients in the three studies in that all of these patients appear to have been motivated to assume the patient role, and there had been numerous hospitalisations for illnesses other than Anorexia Nervosa. In the Mizuta case (Mizuta et al., 2000) the patient's response to confrontation appeared to be typical of a Factitious Disorder patient.

5.2 The Content of the Assessment and the Therapy Sessions:

5.2.1 J's relationship with her mother

While the other studies on co-morbid Anorexia Nervosa and Factitious Disorder emphasised difficulties in family relationships, specifically the emotional distance between the patient and the rest of the family, the studies did not accentuate the relationship between the patients and their mothers. In this study, a predominant theme that emerged both in therapy and in the assessment material was the patient's relationship with her mother. The relationship between J and her mother could be described as enmeshed but depriving. While J and her mother do appear to be close, there is not good communication between them and there appears to be inappropriate boundaries. Both the assessment and the therapy excerpts suggest that J struggles to communicate with her mother and that she perceives her mother as a somewhat punitive figure.

J's exigency appeared to be a difficulty in separating from her mother. A reading of the synthesis of J's history and the Maudsley (see Appendix A) suggests that these difficulties have always been present in that J's mother reported that from the time that J was twelve months old, she struggled with J's motility and separation from her. At the time of J's hospitalisation, J was not permitted to perform simple independent tasks such as preparing her own food, or even serving her own food. Similarly, the T.A.T responses suggest that J wishes to separate from her mother but that she fears the consequences of doing so. Moreover it is her belief that she has to meet the expectations of her mother and devote excessive time to this relationship.

The writing on anorexia nervosa highlights the anorexic's difficulty in her relationship with her mother. As Sours (1974, p. 571) states,

“These patients have been attached to a domineering and controlling mother who attempts to attain passive submission and perfection for the child as her own fulfilment. Power and control exerted by the mother is overwhelming, remarkably interfering with separation and individuation in all phases of the child's development”.

Much of the writing on Anorexia Nervosa traces the route of the anorexic's difficulty in separating and individuating as originating in Mahler's (1968) *rapprochement phase* (Masterson, 1976). During the *rapprochement phase*, the child makes greater use of physical separation. However, if the mother is unable to tolerate the child's attempts at separating, a developmental arrest occurs. Masterson (1976) writes that such mothers may reward the child's regressive or clingy behaviour.

Because this dynamic is recognised as occurring particularly frequently in anorexics (Palazzoli, 1978; Sours, 1974) when J was first admitted this appeared to confirm for the nursing staff that she was anorexic. In J's case, difficulties with separating and individuating appear to be very similar to those difficulties experienced by anorexic patients. Thus this dynamic may be a common dynamic in both Factitious Disorder and Anorexia Nervosa.

5.2.2 High Parental Expectations:

It was mentioned above that J perceived her mother to hold high expectations of her. The TAT responses suggest that J perceives both her parents to have unrealistic expectations

of her. Bruch (1978) discusses the anorexic's drive to perfectionism and their perception that their parents hold high expectations of them. This appears to be another way that J initially appeared to present as an anorexic patient. Thus this may be another common dynamic in factitious Disorder and Anorexia Nervosa.

5.2.3 Over-identification with the Patient role:

In both the assessment and in therapy, there appeared to be an over-identification with the patient role. In the T.A.T responses, J referred to hospitals frequently and she viewed them as places of containment when she felt overwhelmed or unable to cope. The responses further suggest that hospitalisation enables J to cope with feelings of alienation or loneliness and that hospitalisation may meet her dependency needs to some extent. Moreover, the responses demonstrated an underlying masochistic dynamic in that the responses suggest a belief that one attains perfection through suffering.

In therapy it emerged that J had maneuvered her admission to Tara in that she had persuaded her therapist and her parents that Tara would be a suitable place for her to recover. Once J was admitted, her primary anxiety appeared to be remaining in Tara. Unlike the anorexic patients, J wished to have her date for discharge extended and appeared to wish to convince the staff of the fact that she had numerous problems. She thus appeared to be invested in the patient role. Unlike the anorexic patients on the ward, the content of J's therapy sessions revealed that while there was some anxiety about weight gain she was not as anxious about the weight gain as she was about the consequences of the weight gain.

The fact that J did not appear to exhibit any major concerns about her body image appeared to be a pivotal difference between J and the anorexic patients on the ward. Linked to this, J did not appear to be “frantically preoccupied with food and eating” (Bruch, 1978, p.32; DSM-IV, 1994; Mickley, 1983). Thus anorexia appeared to *mask* J’s underlying need to be a patient. While J initially appeared to meet the diagnostic criteria for anorexia nervosa, a closer examination of her behaviour illustrated that she did not have:

- (i) A relentless pursuit of thinness that is accompanied by body image disturbance of delusional proportions.
- (ii) A deficit in the accurate perception of bodily sensations. This is manifested as a lack of awareness and a denial of fatigue (Bruch, 1973, p. 6).

The therapy sessions and J’s assessment illustrated that J did have a “pervasive sense of ineffectiveness” (Bruch, 1973, p. 6). The sense of ineffectiveness is another similarity between J and anorexic patients. Bruch (1973) notes that the anorexic’s preoccupation with controlling the body needs to be understood in this context. In J’s case however, in the face of ineffectiveness, she needed to assume the patient role in order to cope. Being hospitalised enabled her to control her body and the reactions of those around her, while at the same time she was enabled to satisfy her need for attention.

5.2.4 The Body

In therapy J referred to her body as a “safety net”, a means of protecting herself from the world. At times when she felt anxious, alone or bored, she would touch her scars from her operations compulsively and she would feel her bones. Thus J’s body functioned as a means of self-soothing. J often complained that she was cut-off or isolated from others and that she felt unable to communicate. Since she found it difficult to express herself in words and she had a difficulty with symbol formation her body acted as a means of soothing or of “comforting herself”.

During J’s time at Tara it became apparent that she had a difficulty with object constancy. When her parents did not visit her as planned or when they were away, J became frantic and despondent. It was noted that at these times she would feel her body more. Similarly she found any conflict with her family difficult and she was unable to tolerate any negative emotions that were expressed. When difficult feelings were expressed, she harboured the belief that the relationships would be damaged irreparably. Coinciding with uncomfortable absences or conflict J utilised her body to cope. During periods of time that J felt were more difficult it was noted that she became focussed on her body.

Thus for this patient, Boris’ (1984, p.437) description of others impacting on the anorexic with “detonating force” appears to be apt. In J’s case, the actions of others had a profound impact on her since she was unable to maintain a sense of object constancy. For J, her *Factitious Disorder and anorexic symptoms* served as a means of distracting her or of providing some relief. Thus J’s body functions as a precursor object (Gaddini & Gaddini,

1970). Boris' (1984) description of the anorexic's inner space appears to describe J's inner space to some extent. Boris (1984, p.437) argues that the anorexic

“sets all her soldiers of vigilance to monitor the space. Thus employed they do not have the time or energy to notice the presence of the object who would otherwise excite desire and envy”.

While J's Factitious Disorder and anorexic symptoms serve as a means of distracting her and of providing some relief, her symptoms are also designed to attract the attention of others and thus to co-opt the object. Thus in J's case, while the body functions as a precursor object, there appears to be a greater involvement of others than what is typically seen in anorexic patients. This appears to confirm the writing of Hirsch (1994) who suggested that while the body functions as a pre-cursor or transitional object in both Anorexia Nervosa and Factitious Disorder, in the Factitious Disorder patient there also appears to be a greater involvement of others, or a triangulation that occurs.

5.3 The Process of the Therapy Sessions:

5.3.1 Difficulty In Establishing Rapport

Within therapy, it was difficult to establish a therapeutic relationship with J and she was very sensitive to anything that could be construed as criticism. The patient often gave the impression of talking to herself during therapy in that she gave long commentaries about her life without talking to the therapist. The patient's communication was understood as using her language in what has been termed an “autocentric” mode by Bach (1977) in that the patient utilised speech for her own well being, rather than for communicating. The therapist's experience was to feel “talked at” rather than “talked to”. In writing about anorexic patients, Rizutto (1988) noted that this experience of being “talked at” is

usual and the confusion and misunderstanding of anorexic patients during psychotherapy has been well documented.

In addition to this, J demonstrated difficulty in accepting or utilising interpretations that were made. As Balint (1968, p. 19) writes of the basic fault,

“We give the patient an interpretation, clear, concise, well founded and to the point, which often to our surprise, dismay, irritation or disappointment either has no effect on the patient or has an effect quite different from that intended”.

Moreover, there was a lack of connection between the therapy sessions which could be understood as the patient’s fragmentation. This has been termed a “lack of connecting bridges” between various parts of the psyche (Giovacchini, 1990, p.80). Thus in therapy, the therapist had to concentrate on holding and mirroring the patient or on providing what Ogden (1990) has termed a “background matrix” so the patient could discover herself.

These difficulties in therapy are indicative of an underlying personality disorder, particularly a narcissistic personality disorder (Feldman, 1995; Mayo & Haggerty, 1984; Nadelson, 1979; Rizzuto, 1998; Spiro, 1968). In this way, the treatment of patients suffering from Anorexia Nervosa and Factitious Disorder may require similar treatment approaches. *Due to the fact that the developmental arrest is at the pre-verbal level, the therapist needs to focus on providing a holding and containing environment* (Seinfeld, 1993).

5.3.2 Confrontation

While confrontation with anorexics may be difficult, unlike the literature on Factitious Disorder, it is not emphasised within the literature as a particular stumbling block. The most difficult decision that had to be taken by the clinical team at Tara was how to confront J. This dilemma about confrontation is encapsulated in Eisendrath's (1989) writings on Factitious Disorders. According to Eisendrath, the health care professional is in a quandary when faced with a Factitious Disorder patient. The critical decision is whether to confront the patient or not and if the decision to confront the patient is made, the issue is how to confront the patient. Eisendrath (1989) highlights the importance of the patient being able to save face and thus argues for an indirect approach where the importance of the patient's defence is recognised.

In the case of J, when she was confronted about her 'depression', she was presented with a therapeutic double bind (Eisendrath, 1989). She was informed that the therapeutic team had tried everything and that if she did not respond to treatment she would have to be placed in a lock up ward. Thereafter her depression improved dramatically.

In the case of the feigned epileptic seizures, the confrontation of J was more direct. J experienced the confrontation as an attack and she was unable to save face. Her response was thus to respond angrily and to flee treatment. J's response to confrontation is highlighted by the literature as being typical of Factitious Disorder patients (Eisendrath, 1989; Feldman, 1996; Hollender & Hersch, 1970; Mayo & Haggerty, 1984). J's

response to confrontation could have been predicted in that she found it difficult to form relationships and she was extremely sensitive to interpretations. If interpretations were experienced as difficult, confrontation proved to be unbearable. This further emphasises that caution that needs to be exercised when confronting a patient with Factitious Disorder and suggests that an indirect approach may have more favourable long-term consequences.

The issue of confrontation also raised counter-transference issues for the therapist in that the therapist became increasingly skeptical of the patient and she felt somewhat betrayed by the patient. This dovetails with the literature on the counter-transference that arises when working with Factitious Disorder patients (Feldman & Feldman, 1995, Eisendrath, 1989). The literature highlights that the therapist's counter-transference can be an impediment in the treatment of Factitious Disorders but that the therapist may also utilise their feelings in order to arrive at a better understanding of the patient. In this case, while the therapist was conscious of her feelings and attempted to adopt a neutral stance, the patient detected the subtle differences in the therapist's attitude. This further emphasised the patient's acute sensitivity to others.

5.4 Conclusion

This study shares many similarities with the other studies on co-morbid Factitious Disorder and Eating Disorders. While the other studies have stated that the diseases occur co-morbidly it has been argued that as in this study, the Factitious Disorder may actually

have been pre-eminent. As in this study, in all three of the studies, the patient's need to assume the patient role was emphasised.

This study highlighted that J and her mother have a particular pattern of relating that could be described as enmeshed but depriving. Similar to anorexic patients J appears unable to separate from her mother. Due to this dynamic being a particularly common dynamic in anorexic patients, this appeared to support J's initial diagnosis of Anorexia Nervosa. Similarly, J's perception of high parental expectations appeared to be similar to the anorexics need for perfection.

J demonstrated a *disturbed relationship to her body*. It has been argued that her factitious and anorexic symptoms serve as a means of distracting her and of providing relief and thus her body functions as a transitional or precursor object. While this is the case, her symptoms are also designed to co-opt the object in that there is a triangulation that occurs. This is more consistent with a diagnosis of Factitious Disorder as opposed to Anorexia Nervosa.

Linked to this, there appeared to be *an over-identification with the patient role*. It has been argued that unlike anorexic patients J was not concerned about weight gain but rather about the consequences of the weight gain in that weight gain would lead to her discharge. She did not demonstrate any major concerns about her body image and she was not preoccupied with food and eating. Thus in J's case *her anorexia masked her underlying need to be a patient*.

In therapy, J appeared to demonstrate difficulty in tolerating interpretations. This coupled with her difficulty to communicate as well as the lack of connection between the therapy sessions, suggest that the therapeutic interaction centered around narcissistic issues. Many of these issues emerge in the treatment of anorexic patients thus it was argued that the treatment of patients suffering from Anorexia Nervosa and Factitious Disorder may actually be similar. It has been argued that the therapist should focus on holding and containing the patient.

Due to this patient's extreme sensitivity to others she experienced confrontation as intolerable and she left treatment after being confronted about her factitious symptoms.

5.5 Evaluation of the Research

5.5.1 Limitations of this study:

- (i) The case-study method is located within a particular discourse. A reader from a scientific-empiricist paradigm may criticise this study, particularly since from that perspective, the results of this study cannot be generalised.

- (ii) Due to the paucity of information on co-morbid Anorexia Nervosa and Factitious Disorder, the writer had to rely on the three articles. Moreover, these three articles did not include extensive transcripts. Thus the writers ability to analyse the dynamics in the three cited cases was limited to what those authors chose to put on paper.

5.5.2 Strengths of this Study:

- (i) The advantage of this study lies in the fact that it has been a thorough investigation into a segment of an individual's life (Bromley, 1968). This has resulted in an understanding of the intricate dynamics that are involved in this individual's life.

- (ii) An extensive literature search indicated that co-morbid eating disorders and Factitious Disorders are extremely rare. Thus this study is contributing to an understanding of co-morbid Anorexia Nervosa and Factitious Disorder. Moreover this study has been written within an object relations perspective and thus has contributed to an object relations perspective on co-morbid Anorexia Nervosa and Factitious Disorder.

- (iii) It has been argued that in this patient the Factitious Disorder was the primary diagnosis and that this patient had anorexic symptoms. Thus this contributes to an understanding of how Factitious Disorders may present.

- (iv) This study has contributed to an understanding of the similarities and differences between Factitious Disorder and Anorexia Nervosa. This may assist clinicians in differentiating between Factitious Disorder and Anorexia Nervosa.

- (v) The fact that the research has relied on different sources of information (the history, the assessment and psychotherapy notes and transcripts) is another strength in that it increases the validity of this study.

5.6 Recommendations:

- (i) There needs to be further research on patients who present with co-morbid Anorexia Nervosa and Factitious Disorder in order to ascertain whether in these patients the diagnosis of Factitious Disorder is the primary diagnosis.
- (ii) Further research should also be undertaken on patients diagnosed as suffering from Anorexia Nervosa in order to explore whether and to what extent some anorexic patients are motivated to assume the patient role.
- (iii) Further research into the similarities and differences between Factitious Disorder and Anorexia Nervosa may assist clinicians in differentiating between them.
- (iv) The similarities between Factitious Disorder and Anorexia Nervosa hold implications for therapists in that the treatment may be similar.

CHAPTER 6: REFERENCES

- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual IV*. Washington, DC: American Psychiatric Association.
- Asher, R. (1951). Munchausen's Syndrome. *Lancet*, *1*, 339-341.
- Bach, S. (1977). On the narcissistic state of consciousness. *International Journal of Psycho-analysis*, *58*, 209-233.
- Balint, M. (1968). *The basic fault: Therapeutic aspects of regression*. London: Tavistock Publications.
- Bellak, L. (1963) *The thematic apperception test, the children's apperception test and the senior apperception test*. New York: Grune & Stratton.
- Berliner, B. (1947). On some psychodynamics of masochism. *Psychoanalytic Quarterly*, *16*, 459-471.
- Boris, H. N. (1984). On the treatment of Anorexia Nervosa. *International Journal of Psychoanalysis*, *65*, 435-442.
- Bromberg, P. M. (1986). The mirror and the mask. On narcissism and psychoanalytic growth. In A. P. Morison (Ed.), *The essential papers on narcissism* (pp. 76-89). New York: New York University Press.
- Bromley, D.B. (1986) *The case-study method in psychology and related disciplines*. Chichester, UK: John Wiley and Sons.
- Bruch, H. (1978). *The golden cage: The enigma of Anorexia Nervosa*. Cambridge, Massachusetts: Harvard University Press
- Bruch, H. (1973). *Eating disorders: Obesity, Anorexia Nervosa and the person within*. Routledge and Kegan Paul: London.
- Bruch, H. (1994). *Conversations with anorexics: A compassionate and hopeful journey through the therapeutic process*. Northvale, New Jersey: Jason Aronson.
- Buck, J.N. (1958) The case of r. In J. Hammer (Ed.), *The clinical application of drawing* (6th Ed.), (pp. 276-308) Springfield, Illinois: Charles.C.Thomas Publishers.
- Bulik, C. M., Sullivan, P. F., Fear, J. L., & Pickering, A. (1996). A case of co-morbid Anorexia Nervosa, Bulimia Nervosa and Munchausen's Syndrome. *International Journal of Eating Disorders*, *20* (2), 215-218.

- Burge, C. K. & Lacey, J. H. (1992). A case of Munchausen's Syndrome in Anorexia Nervosa. *International Journal of Eating Disorders*, 14 (3), 379-381.
- Dohn, H. H. (1986). Factitious rape: a case report. *Hillside Journal of Clinical Psychiatry*, 8, 224-231.
- Edwards, D.J.A. (1998). Types of case study work: A conceptual framework for case-based research. *Journal of Humanistic Psychology*, 38, 36-70
- Eisendrath, S. J. (1984). Factitious illness: A clarification. *Psychosomatics*, 25, 110-117.
- Eisendrath, S. J. (1989). Factitious Physical Disorders: Treatment without confrontation. *Psychosomatics*, 30, 383-387.
- Eisendrath, S. J. (1996). Current overview of Factitious Physical Disorders. In M. Feldman (Ed.), *The spectrum of factitious disorders* (pp. 21-37). Washington, DC: American Psychiatric Press.
- Farrell, E. M. (1995). *Lost for words: The psychoanalysis of Anorexia and Bulimia*. London: Process Press.
- Feldman, M. & Feldman, J. (1995). Tangled in the web: Countertransference in the therapy of Factitious Disorders. *International Journal of Psychiatry in Medicine*, 25 (4), 389-399.
- Feldman, M. & Ford, C.V.(1994) *Patient or pretender: Inside the strange world of Factitious Disorders*. New York: John Wiley & Sons.
- Feldman, M. (1996). *The spectrum of Factitious Disorders*. Washington, DC: American Psychiatric Press.
- Ferenczi, S (1933). Confusion of tongues between adult and child. In S. Ferenczi (1955) *final contributions to the problems and methods of psychoanalysis*. New York: Brunner Mazel.
- Ford, C.V. (1973). The Munchause Syndrome. A report of four new cases and a review of the psychodynamic considerations. *Psychiatry in Medicine*, 4, 31-45.
- Gaddini, R. & Gaddini, E. (1970) Transitional objects and the process of individuation: A study in three social groups. *Journal of American Academic Child Psychiatry*, 9, 347-365.
- Giovacchini, P.L.(1990). Interpretations, an obscure technical area: Comments on Winnicott's interpretation in psycho-analysis. In Giovacchini, P.L.(Ed.), *Tactics and techniques in psychoanalytic therapy: The implications of Winnicott's contributions*. (pp. 71-89). Northvale, New Jersey: Jason Aronson Inc.

- Grolnick, S. (1990). *The work and play of Winnicott*. New Jersey: Jason Aronson Inc.
- Groth-Marnat, G. (1997). *Handbook of psychological assessment*, (3rd ed.). New York: John Wiley & Son.
- Hammer, J. (1958). *The clinical application of projective drawing* (6th ed.). Springfield, Illinois: Charles. C. Thomas Publishers.
- Hepworth, J. (1999). *The social construction of Anorexia Nervosa*. London: Sage Publications.
- Hirsch, M. (1994). The body as a transitional object. *Journal of Psychotherapy and Psychosomatics*, 62, 78-81.
- Hollender, M. & Hersch, S. R. (1970). Impossible consultation made possible. *Archives of General Psychiatry*, 23, 343-345.
- Justus, P. G & Kreutziger, J. (1980). Probing the dynamics of Munchausen's Syndrome. *Anal of Internal Medicine*, 93, 120-127.
- Kafka, J.S. (1969). The body as a transitional object: a psychoanalytic study of a self-mutilating patient. *British Journal of Medical Psychology*, 42, 207-212
- Libow, J. A. (2000). Child and adolescent illness falsification. *Pediatrics*, 105 (2), 336-342.
- Mahler, M. S., Pine, F. & Bergman, A. (1975). *The psychological birth of the human infant*. New York: Basic Books.
- Mahler, M. S. & Kaplan, L. (1977). Developmental aspects in the assessment of narcissistic and so-called borderline personalities. In M. D. Hartocollis (Ed.), *Borderline personality disorders. The concept, the syndrome, the patient* (pp. 71-85). London: International Universities Press.
- Mahler, M. S. (1968). *On human symbiosis and the vicissitudes of individuation. Vol I. Infantile psychosis*. New York: International Universities Press.
- Mahler, M.S. (1986) On the first three subphases of the separation-individuation process. In P. Buckley (Ed.), *Essential papers on object relations* (pp. 222-232) New York: New York University Press.
- Malson, H. (1998). *The thin woman: Feminism, post-structuralism and the social psychology of Anorexia Nervosa*. London: Routledge Publications.

- Masterson, J. F. (1976). *Psychotherapy of the borderline adult: A developmental approach*. New York: Brunner-Mazel.
- Masterson, J. F. (1977). Primary Anorexia Nervosa in the borderline adolescent – an object relations view. In M. D. Hartocollis (Ed.), *Borderline personality disorders. The concept, the syndrome, the patient* (pp. 475-494). London: International Universities Press.
- Maykut, P. & Morehouse, R. (1994). *Beginning qualitative research: A philosophic and practical guide*. London: The Falmer Press.
- Mayo, J. P. & Haggerty, J. J. (1984). Long term psychotherapy of Munchausen Syndrome. *American Journal of Psychotherapy*, 4, 571-579.
- Meissner, W..M. (1984) *The borderline spectrum: Differential diagnosis and developmental issues*. New York: Jason Aronson.
- Mizuta, I., Fukunaga, T., Sato, H., Ogasawara, M., Takeda, M., & Inoue, Y. (2000). A case of co-morbid eating disorder and Factitious Disorder. *Psychiatry and Clinical Neurosciences*, 54, 603-606.
- Nadelson, T. (1996). Historical perspectives on the spectrum of sickness: From “crock” to “crook”. In M. Feldman (Ed.), *The spectrum of Factitious Disorders* (pp. 1-27). Washington, DC: American Psychiatric Press.
- Nadelson, T. (1979). The Munchausen spectrum: Borderline character features. *General Hospital Psychiatry*, 1, 11-17.
- Nordemeyer, J. P. (1994). An internist’s view of patients with Factitious Disorders and factitious clinical symptomatology. *Journal of Psychotherapy and Psychosomatics*, 62, 30-40.
- Ogden, T. H. (1990). *The matrix of the mind: Object relations and the psychoanalytic dialogue*. Northvale, New Jersey: Jason Aronson Inc.
- Paar, G.H. (1994). Factitious Disorders in the field of surgery. *Journal of Psychotherapy and Psychosomatics*, 62, 41-47
- Palazzoli, M. S. (1978). *Self starvation: from individual to family therapy in the treatment of Anorexia Nervosa*. New York: Jason Aronson Inc.
- Papadopolous, M.C. & Bell, B.A. (1999). Factitious neurosurgical emergencies: A report of five cases. *British Journal of Neurosurgery*, 13 (6), 591-593.

- Parker, P. E. (1996). Factitious Psychological Disorders. In M. Feldman (Ed.), *The spectrum of Factitious Disorders* (pp. 37-50). Washington, DC: American Psychiatric Press.
- Plassmann, R. (1994). Munchausen Syndromes and Factitious Diseases. *Journal of Psychotherapy and Psychosomatics*, 62, 7-26.
- Reich, P. & Gottfried, L. A. (1983). Factitious Disorders in a teaching hospital. *Annals of Internal Medicine*, 99, 240-247.
- Rizzuto, A. M. (1988). Transference, language and affect in the treatment of bulimarexia. *International Journal of Psychoanalysis*, 69, 369-387.
- Seinfeld, J. (1993) *Interpreting and holding: The paternal and maternal functions of the psychotherapist*. Northvale, New Jersey: Jason Aronson Inc.
- Silber, T. J. (1987). Acquired pseudo eating disorder: An imitation or fabrication of Anorexia Nervosa. *Journal of Adolescent Health Care*, 8, 452-455.
- Sohn, L. (1985). Anorexic and bulimic states of mind in the treatment of anorexic-bulimic patients and psychotic patients. *Psychoanalytic Psychotherapy*, 1, 49-56.
- Sours, J. (1974). The Anorexia Nervosa syndrome. *The International Journal of Psychoanalysis*, 55, 567-576.
- Spiro, H. R. (1968). Chronic Factitious Illness. *Archives of General Psychiatry*, 18, 569-579.
- Stone, M.H. (1977) Factitious Illness: Psychological findings and treatment recommendations. *Bulletin of the Menninger Clinic*, 41, 239-254.
- Sugarman, A. & Kurash, C. (1981). The body as a transitional object in bulimia. *International Journal of Eating Disorders*, 1, 57-66.
- Sugarman, A., Quinlan, D. & Devenis, L. (1981). Anorexia Nervosa as a defence against anaclitic depression. *International Journal of Eating Disorders*, 1, 44-61.
- Winnicott, D. W. (1971). *Playing and reality*. Middlesex: Penguin Books
- Winnicott, D. W. (1953). Transitional objects and transitional phenomena. A study of the first not me possession. *International Journal of Psychoanalysis*, 34(2), 89-97.
- Winnicott, D.W. (1956). *The collected papers. Through pediatrics to psychoanalysis*. London: Tavistock Publications.

Yin, R. K (1994). *Case study research: Design and methods*. London: Sage Publications.

Zerbe, K. J. (1992). Eating disorders in the 1990's: Clinical challenges and treatment implications. *Bulletin of the Meninger Clinic*, 56, 167-187.

APPENDIX A

MAUDSLEY CASE HISTORY AND MEDICAL STATE EXAMINATION

NAME: J
ADDRESS: J resides with her mother and father in Johannesburg
AGE: 22
DATE OF BIRTH:
MARITAL STATUS: Single
HIGHEST LEVEL OF EDUCATION: Student, currently in her 3rd year of a Bachelor of Commerce degree at Rand Afrikaans University.
FIRST LANGUAGE: English
RELIGION: Christian, Charismatic
DATE OF ADMISSION: 28 August 2001

REASON FOR REFERRAL:

J's psychologist referred her to the Tara Eating Disorders Unit due to her loss of weight.

HISTORY:

Sources of information: The patient J.
The patient's parents.

THE PRESENTING PROBLEM:

(i) Anorexia Nervosa:

J's psychologist referred her to Tara due to her loss of weight and her restrictive eating pattern. At the time of the admission, J weighed 48,2 kilograms and was 13,7% under weight.

J reported that she had been amenorrhoeic since August or September 2000. She said that she had an extreme fear of atness and had a distorted body image in that she expressed the belief that she "could still lose one or to more kilograms" and she felt fat. She reported hating certain foods such as meat, fish and chicken as well as "fatty foods" such as rice and butter. J's restrictive eating resulted in her feeling "in control" and "better" about herself. J self-diagnosed herself and referred to herself as "an anorexic".

J's parents reported that they had been alarmed by J's recent attitude towards food.

(ii) Epilepsy

J reported that on a few occasions she had "lost consciousness totally" and she "blanks out". She elaborated on this to mean that she may have been

experiencing a seizure. She reported that at these times she feels angry and she "hates herself".

This was J's second admission to Tara. In July 1995 she was admitted to Tara Hospital for anorexia. At the time of J's first admission she was 31% underweight. In December of 1995 she refused hospital treatment and her parents agreed to take her home.

SIGNIFICANT LIFE EVENTS:

J listed the following as significant life events:

- i) Being hospitalized in Tara in 1995 for anorexia. She experienced the separation from her family, particularly her mother as "very difficult". She stated that the hospitalization helped her to "turn the anorexia around", in that she "regained control" after the hospitalization.
- ii) In 1996, J completed her standard 9 and matric in one year. She gained a university exemption.
- iii) J stressed her academic achievements at University as being highly significant.

HIGHEST LEVEL OF ADAPTIVE FUNCTIONING:

J is currently in her 3rd year of a Bachelor of Commerce degree at RAU University. While she appears to be performing adequately academically she reports some marked difficulties in her interpersonal relationships in that she does not have any close friends. She still lives at home and is very dependent on her mother.

FAMILY HISTORY:

Parents:

Father: J's father is an engineer. He was recently retrenched after working for 26 years. J has a "difficult" relationship with her father. She attributes this to the fact that she finds it "difficult to talk to him". She said that he did not involve himself when she was a child but that since his retrenchment he spends more time at home. She added that she thought he had a drinking problem.

J's mother is a receptionist at the church. She is very close to J and is "more like a sister or a friend". J finds it very difficult to disagree with her mother. She confides in her mother and tells her mother everything. Further, J reported that she has always been her mother's "favourite child". J reported that her mother has suffered from depression throughout her childhood and that she has had to "look after her mother" due to this.

J described the relationship between her parents as “okay” but she said that there has been a lot of tension between her father’s retrenchment.

Siblings: J has a brother who is nineteen years old. He does not live at home and he is working in . J described her brother as successful and outgoing.

Home Atmosphere and Influence:

J depicted her early childhood as idyllic. She described it as “perfect” and “happy”. She reported that she had not liked going to school in that she had “missed her mother”.

J’s family is very religious and religion plays an important role in the lives of J’s parents.

J’s father has recently been retrenched and this has had an impact on this family in that they are “not as rich” as previously.

Familial Psychiatric and Medical Illnesses:

J’s mother has suffered from depression intermittently and was hospitalized in Tara’s Adult ward.

PERSONAL HISTORY:

Pregnancy and Birth:

Pregnancy and birth: J’s mother had always longed for a girl-child. She told J that she had wanted “a little daughter” or a “little friend”. The pregnancy and birth process were normal and healthy. J’s mother had been “delighted” and “thrilled” when J was born. J’s birth was “normal”.

Early Development:

From the time that she was an infant, her mother formed a very close bond with her.

All J’s milestones were reported to have been normal but she started to walk relatively late.

J’s mother reported that she had found it difficult when J started to become more independent. She had worried about J when she had started walking.

J’s mother emphasised that she had been toilet trained quickly and that J had reached her milestones ahead of other children her age. She attributed this to the fact that J is ‘very bright’.

Neurotic Symptoms in Childhood:

J reported that she had frequent nightmares as a child due to her fear of being alone and the dark. She reported that she did not like to go to nursery school and school.

J hated to be separated from her mother.

Health During Childhood:

Apart from the usual childhood illnesses such as chicken pox and measles, J was a healthy child.

Personality in Childhood and Adolescence:

J was described as having been a quiet and shy child and adolescent. Due to her temperament her parents, particularly her mother conceded that they may have been "overprotective".

It was during J's childhood that she and her mother became "inseparable".

Menstrual History: J reported menstruating at 13. She stopped menstruating during her first admission to Tara. She is currently not menstruating.

Intimate and Close Relationships:

J has never had a boyfriend. She reported that she has "very few friends" and she attributed this to the fact that she has been ill.

Her parents also raised J's lack of relationships as a problem.

Education:

At school J excelled both academically and on the sports field. She had her provincial colours for hockey.

J always struggled to make friends.

Further Education:

J is currently in her 3rd year of a B Com degree. She has excelled academically.

Occupation: Student

Present Home Circumstances J resides with her mother and father in Johannesburg.

Previous Illnesses:

Psychiatric History:

J suffered from anorexia nervosa in **1995**, she was 16 years old and in standard nine. She was conscious of her body due to the fact that it was "sporty" and comparatively mature. She began to limit her caloric intake and enjoyed the "control" that she could exert over her body. She was playing in the Transvaal hockey team and she began to exercise excessively. She would play matches without having eaten. She exhibited an intensive fear of putting on weight. While depriving herself of food she remained "obsessed" with food and she used to store and hide food in her room. Her weight plummeted to around 40 kilograms and she was 31% underweight. She reported that at the time of her first admission she had "looked like a skeleton". She was admitted to Tara in July of 1995 and as discharged in December when she refused hospital treatment and her parents took her home.

Medical History:

J reported that since 1997 she has been very ill with recurrent bladder infections, interstitial cystitis. During 1997 she was admitted to The Milpark Clinic and the Garden City Clinic for treatment of her bladder.

During this year she reported that she had had three grande mal epileptic seizures and that she had also been using laxatives since she was concerned about her weight. At this juncture her doctors were Drs Smart and Vickers and she was treated with DMSO, Heparin and cystoscopies.

In June 1999 she had an augmentation cystoplasty by Dr Gecelter and then a YV plasty of her bladder neck.

In March 2000 she had a total cystectomy with a small bowel orthotopic bladder replacement.

She has been experiencing recurrent urinary tract infections since that time. Dr Fisher is treating J for her urinary problems. He stated that Julie should be kept on long term, low dose urinary antiseptics.

J has also recently been diagnosed with Crohn's disease. J said that her urinary tract problems and her difficulties with catheterising herself in tandem with the Crohn's disease exacerbated her anorexia. She elaborated on this and said that she would rather not eat since when she ate she would have to catheterise herself more regularly.

BASIC PERSONALITY

Self and Others' Perceptions:

Initially J was unable to describe herself.

She said that she is "very worried" about pleasing her parents. She described herself as being perfectionistic and she has always excelled at school, at sport and academically.

Recently she has been preoccupied about doing very well at University and she has concentrated on her work to the detriment of any social life. She complained that in the months prior to her admission she had felt very withdrawn and "cut-off" from her peers. She said that she also has mood swings and that she sometimes feels very "sad". J said that recently she has felt increasingly suicidal and she has often contemplated "ending her life".

Clinical Impressions:

My clinical impressions are that the patient is a withdrawn young woman who struggles to communicate with others.

She appears to have a very poor sense of self and a lack of self esteem.

MENTAL STATE EXAMINATION

J presented as a very thin, well –groomed tall young woman .She was quite tearful during the interview but appeared willing to talk. She described her mood as being 'very down'. She said that she has been suicidal recently.

She said that she had found it difficult to be at Tara since she was missing her mother and family. She emphasised that she did not think that she had an eating disorder since she was "not as thin as the others" and also that she had weighed much less at the time of her first admission. She expressed the opinion that her problems were "greater than the other anorexics" since she had to come to terms with the trauma of her operations.

No disturbances in thinking or perception were reported or detected. Her sound performance on the tests of similarities and proverbs demonstrated a good ability for abstract thought. The patient did demonstrate some insight into her personality and her behaviour, albeit limited, in that she was able to draw links between the past and her present behaviour.

The patient was able to complete the serial seven task counting backwards from 100 quickly and accurately. On immediate recall and intermediate recall (25 minutes) she was able to name 4/5 objects. This would suggest that she has a good concentration and working memory.

From a detailed and clear history(with the possible exception of the medical history) it appears that the patient's long term memory is intact.

VALIDITY OF THE HISTORY:

No reason is found to question the validity of the history

CASE FORMULATION

SUMMARY OF SIGNIFICANT DATA:

J is a 22 year old, third year university student who resides with her parents. She has been admitted to Tara's Eating Disorder Unit due to severe weight loss. This is her second admission for Anorexia Nervosa.

HIGHLIGHTS OF THE HISTORY AND THE MENTAL STATE EXAMINATION:

- (i) J is the oldest child in a conservative, religious family. She portrays her early childhood as idyllic.
- (ii) J's mother reported that she experienced J's early attempts at motility as difficult. It was emphasised that J was 'more advanced than other children her age" and that she met her milestones qickly.
- (iii) J was a quiet and withdrawn child who struggled to make friends. Her aacademic performance at school was emphasised.

- (iv) J suffered from anorexia nervosa in **1995**, when she was 16 years old. She began to limit her caloric intake and enjoyed the “control” that she could exert over her body. Her weight plummeted to around 40 kilograms and she was 31% underweight. She was admitted to Tara in July of 1995 and as discharged in December when she refused hospital treatment and her parents took her home.
- (v) Since 1997, J has been hospitalised numerous times.
- (vi) J has a very close relationship with her mother and appears unable to separate from her mother.

PROVISIONAL DIAGNOSIS:

Diagnosis on Admission:

AXIS I	Anorexia Nervosa Major Depressive Episode (?)
AXIS II	Some OCPD traits
AXIS III	Crohn’s Disease Epilepsy
AXIS IV	Relationship problems
AXIS V	GAF: 40-50

A BRIEF PSYCHOLOGICAL FORMULATION:

It appears that the patient’s early relationship with her mother was markedly symbiotic and there appears to have been a lack of differentiation between them. She described herself as her mother’s ‘favourite child’. Thus this patient appears to have an enmeshed relationship with her mother. Further, there appears to be an inversion of mother child roles in that J has had to act as a *container* for her mother’s anxiety (in terms of Bion’s theory).

The patient appears to be isolated from others and she appears to have a poor sense of self. She appears to have marked dependency needs. Her thinness prompted the environment and her mother to take care of her but resulted in a further sense of dependency. Her recent illnesses have resulted in a further dependency on her parents.

MANAGEMENT RECOMMENDATIONS:

Psychological: Short term depth Psychotherapy is found to be suitable for this patient. The consolidation of the therapeutic alliance is crucial. The therapists role is to be a good-enough therapist (in terms of Winnicott’s

theory). The therapist would need to be empathically in touch with the patient's needs and to respond with understanding, support and necessary deprivation.

PROGNOSIS:

If good rapport is established, the prognosis may be good.

DISCHARGE INFORMATION:**(i) DIAGNOSIS AT DISCHARGE:**

AXIS I	Factitious Disorder Anorexia Nervosa (?)
AXIS II	Some OCPD traits
AXIS III	Crohn's Disease Epilepsy (?) Epilepsy scans were normal. Patient was found to be inducing epilepsy
AXIS IV	Severe Relationship problems
AXIS V	GAF: 50-60

(ii) INVESTIGATIONS:

- **Psychological:** Projective testing was done. The results of the tests suggest that J has a very poor sense of self. Linked to this, she has a poor body image and she seems very preoccupied with her body and also with food. She appears to have an enmeshed relationship with her mother and is highly concerned about complying with her needs to the detriment of her own needs. A very strong theme in the material was J's identification with the patient role and to some extent it appears that her needs are met through assuming the role of a patient.
- **Medical:** A sleep deprived EEG was conducted. The record was normal. No focal or epileptic features were revealed.

(iii) THERAPEUTIC PROGRESS:

J commenced the anorexic programme on a 1,500 calorie diet. She initially struggled to utilise the therapeutic space and was sometimes reluctant to engage with the therapist. J's difficulties on the programme were compounded by the fact that she missed her mother very much and she felt isolated and unable to connect with the other patients. Immediately after J's admission she expressed suicidal feelings and she was placed under special observation several times. When J was informed that she may be moved to another ward she stopped reporting suicidal feelings and said that her depression had "lifted".

J did not consistently gain weight on the programme. Her weight gain appeared to fluctuate. It was sometimes hard to engage with J in therapy in that there was often a disjointed quality from session to session. J was

sometimes angry with the therapist for setting limits but she found it difficult to verbalise this.

The therapist also had family therapy meetings with J's parents and J on a monthly basis. J's mother appears to be depressed and she found it very difficult to tolerate any negative feelings or emotions that were expressed. J's father appeared somewhat more able to tolerate difficult emotions and also to set limits with J. These sessions focussed on practical parenting issues. Some work centred around the dynamics within the family such as the enmeshed relationship between J and her mother and also the pattern of blame and guilt within this dyad. J-'s family needed a lot of containing and holding while J was in Tara.

On some occasions it was necessary to confront J's mother since she was seen bringing medication into the ward. J was confronted about taking medication to induce an epileptic seizure. After this confrontation J was discharged.

APPENDIX B

PSYCHOLOGICAL ASSESSMENT

CONFIDENTIAL NOT TO BE USED FOR FORENSIC PURPOSES

DEMOGRAPHIC INFORMATION:

Name: J

Age: 22 years old

Sex: Female

Highest Level of Education: Currently in her 3rd year of a Bachelor of Commerce Degree at R.A.U.

Residence: J resides with her mother, father and brother in Johannesburg.

Religion: Christian

Date of admission: 28th August 2001

REFERAL SOURCE:

Professor Szabo referred J for assessment in order to assess her emotional functioning.

THE PRESENTING PROBLEM:

J's psychologist referred her to Tara due to her loss of weight and her restrictive eating pattern. At the time of her admission J weighed 48,2 kgs and was 13,7% under weight.

J reported that she had been amenorrhoeac since August or September 2000. She said that she had an extreme fear of fatness and had a distorted body image in that she expressed the belief that she "could still lose one or two more kilograms" and she felt fat. She reported hating certain foods such as meat, fish and chicken as well as "fatty foods" such as rice and butter. J's restrictive eating resulted in her feeling "in control" and "better" about herself.

This was J's second admission to Tara. In July 1995 she was admitted to Tara Hospital for anorexia. At the time of J's first admission she was 31% under weight. In December of 1995 she refused hospital treatment and her parents agreed to take her home.

BACKGROUND:

J is a twenty -two year old girl who lives with her mother and father and her younger brother in Johannesburg. Her family was reported to be a very close family. Her father, was retrenched in January 2001 after having worked at the company for twenty six years. J's mother works at a church. Religion is very

important to this family and they attend church and church related activities on a regular basis.

Personal History:

(i) **Prenatal and Infancy:**

J's birth was "normal". Her mother stated that she had "longed for" a girl and she had been "thrilled" when J was born. J was healthy when she was born. From the time that she was an infant, her mother formed a very close bond with her. All J's milestones were reported to have been normal but she started to walk relatively late.

J's mother reported that she had found it difficult when J started to become more independent. She had worried about J when she had started walking.

(ii) **Childhood and Adolescence:**

J was described as having been a quiet and shy child and adolescent. Due to her temperament her parents, particularly her mother conceded that they may have been "overprotective". It was during J's childhood that she and her mother became "inseparable". At school J excelled both academically and on the sports field. She had her provincial colours for hockey. During her adolescence her eating disorder emerged for the first time and she became increasingly self-conscious about her "athletic body".

Personality:

J described herself as a passive, dependant and compliant person who is "very worried" about pleasing her parents. She described herself as being perfectionistic and she has always excelled at school, at sport and academically. Recently she has been preoccupied about doing very well at University and she has concentrated on her work to the detriment of any social life. She complained that in the months prior to her admission she had felt very withdrawn and "cut-off" from her peers. She said that she also has mood swings and that she sometimes feels very "sad". J said that recently she has felt increasingly suicidal and she has often contemplated "ending her life". J attributed her depressed feelings to the following:

Medical and Psychiatric History:

In July 1995 J was admitted to Tara Hospital for anorexia. At the time of J's first admission she was 31% under weight. In December of 1995 she refused hospital treatment and her parents agreed to take her home. She said that when she went home she recovered slowly but she was able to complete her Standard 9 and matric in one year. Due to her "focus" on her academic work she was able to "forget about her anorexia" to some extent.

J reported that since 1997 she has been very ill with recurrent bladder infections, interstitial cystitis. During 1997 she was admitted to The Milpark Clinic and the Garden City Clinic for treatment of her bladder. During this year she reported that

she had had three grande mal epileptic seizures and that she had also been using laxatives since she was concerned about her weight. At this juncture her doctors were Drs Smart and Vickers and she was treated with DMSO, Heparin and cystoscopies. In June 1999 she had an augmentation cystoplasty by Dr Gecelter and then a YV plasty of her bladder neck. In March 2000 she had a total cystectomy with a small bowel orthotopic bladder replacement. She has been experiencing recurrent urinary tract infections since that time. Dr Fisher is treating J for her urinary problems. He stated that Julie should be kept on long term, low dose urinary antiseptics. J has also recently been diagnosed with crohn's disease. J said that her urinary tract problems and her difficulties with catheterising herself in tandem with the Crohn's disease exacerbated her anorexia. She elaborated on this and said that she would rather not eat since when she ate she would have to catheterise herself more regularly.

Clinical Interview:

J presented as a very thin, well –groomed tall young woman .She was quite tearful during the interview but appeared willing to talk. She described her mood as being 'very down'. She said that she has been suicidal recently.

She said that she had found it difficult to be at Tara since she was missing her mother and family. She emphasised that she did not think that she had an eating disorder since she was "not as thin as the others" and also that she had weighed much less at the time of her first admission. She expressed the opinion that her problems were "greater than the other anorexics" since she had to come to terms with the trauma of her operations.

EMOTIONAL FUNCTIONING:

□ Draw A Person Test:

J drew a picture of herself. She said that in the picture she is crying and that this is how she is feeling now and generally. She elaborated on this and said that she is "insecure and a failure". She added that she feels "fat and ugly". J erased her drawing repeatedly.

A projective analysis of this drawing indicates that J feels ungrounded and unsupported by her environment. Although she is able to express her needs to some extent, she experiences difficulty in expressing herself appropriately and effectively and she appears to hold the belief that people do not really care for her or respond to her. Linked to this, J appears to have a marked feeling of being inadequate and the posture of the figure in the drawing suggests that she feels uncertain as to how to engage with others.

The mask-like quality of the face in tandem with the stilted quality of the figure further highlights J's withdrawal from others but also emphasises that she adopts a façade in order to cope with the demands of her life. The drawing further suggests that J has unmet dependency needs and that she tends to experience these needs as somewhat overwhelming.

There is a marked sense of anxiety in the drawing particularly surrounding her intellect. This suggests that J experiences an enormous pressure to achieve intellectually. J appears to be acutely aware of her body and she has a distorted body image.

□ **Kinetic Family Drawing**

J drew her family members on the beach on holiday. She is standing with her mother underneath an umbrella. Her father and her brother are engaged in their own pursuits; her father is walking off to talk to someone and her brother is swimming.

The drawing highlighted the fact that J and her mother appear to have a very close relationship. J appears to depend on her mother for emotional support. The posture and the closeness of these figures also suggests that there may be inappropriate boundaries between them and that J's mother also depends upon J for emotional support. Both J and the mother figure in the picture appear to have marked unmet dependency needs.

In contrast to her relationship with her mother, J appears to feel somewhat isolated from her father and her brother. There is an awareness that she is unable to connect with her father and her brother. J appears to be somewhat envious of her brother since she views him as independent and well adjusted. She regards her father with some suspicion and she appears to be concerned that he may be drinking. There is an overarching wish for the reunion of her family. J does not see her home as a nurturing or secure environment and she feels insecure about this.

The distortion of the bodies, particularly her own, further emphasised that J has a distorted body image.

□ **Thematic Apperception Test**

J's responses convey the overarching impression that she has a very poor sense of self. She is struggling with her identity and appears to be very confused about who she is. She appears to be very preoccupied by the environment and by those around her and she appears to experience a pervasive sense of estrangement or dissociation from others. Moreover she appears to experience her environment as a very harsh and censoring one. J has very strong unmet dependency needs but she appears to be unable to express her needs effectively and she feels overwhelmed by her needs.

It appears that **when she feels overwhelmed or anxious, she may resort to the patient role in order to cope**. This was a common theme in J's responses, suggesting an over-identification with the patient role.

The following excerpts illustrate this:

Card 3BM

"Something really bad has happened to her. Things have been building up for a while, and now she has lost control. She's crying her heart out. She can't handle it anymore. She feels hopeless and tired. She is tired of everything. She wants to give up. ...

The way I see it, she ends up in hospital having a nervous breakdown or committing suicide. She lands up in hospital. She is hospitalised....."

This quotation also demonstrates that J is unable to self-soothe and that she has a poor sense of object constancy.

Card 13 MF

"An old man, he's by his wife's side. She has had cancer or some other terminal illness. They really loved each other. He stuck by her. She was a good person but she passed away and so he is crying. Maybe he is crying because he knows she is at peace. She does not have to suffer any more. He has lost his partner, he will miss her....."

J appears to believe that through illness she will attain perfection in her relationships with others.

J's responses further conveyed that she has a number of anxieties about her family. She feels that she is unable to assert herself and that she is responsible for her family members' happiness. She appears to feel that she does not have enough space within the family. Her relationship with her mother appears to be a very enmeshed one and there appears to be a plethora of guilt surrounding this relationship. While J wishes to separate from her mother, she is markedly ambivalent largely due to her strong unmet dependency needs and she is unable to communicate her anxiety with her mother. There is much underlying resentment and rage that J feels she is unable to express since she does not appear to be able to tolerate her negative feeling about her family. J feels disconnected from her father but the stories suggest that she wishes to have a closer relationship with him.

J's stories further conveyed that she is experiencing a lot of family pressure in that there is a lot of conflict between pursuing what she wishes to do and in carrying out her family's wishes for her.

J's internal world is fraught with harsh and persecutory objects. Currently she lacks the capacity to self-soothe in that she feels easily overwhelmed by her experiences. She attempts to cope through magical thinking and the stories reflect that she often resorts to a utopian but unrealistic vision of life. She also utilises splitting in that her world is comprised of stark contrasts between "good"

and "bad" figures and since she appears unable to tolerate her negative feelings and emotions. Moreover J's responses reflect that she utilizes denial as a defense and she refuses to acknowledge any anger or resentment. These defenses may be understood as an attempt to preserve her good internal objects. J's stories demonstrate that she has poor insight into her problems and that she does not have a sense of agency or responsibility for her actions

RECOMMENDATIONS:

- (i) Long -term therapy is recommended for J in order to assist her to develop stronger defenses and a stronger sense of self.
- (ii) Parental counseling is recommended for J's parents in order to assist them to respond to J in a more appropriate manner. J's mother needs to be encouraged to allow J to separate from her.

SIGNED

Jeanne Gaylard
Intern Clinical Psychologist.

Thematic Apperception Test Responses

Card 1

"This boy, maybe like his parents are pushing him to play the violin. He doesn't want to play it. He's miserable. He had a fight with them and he's been pushed and he doesn't enjoy it. Or, he's let them down in some way. He could have been interested in the beginning but now, because he's been pushed so hard, he hates the violin. He did enjoy it when he started out. Eventually he stops. That's all".

Card 2

"This picture, the mother is very strict. The girl with the books is very innocent. The mother keeps a careful eye on her. The man in the background is carefree... He just has to look after the horses whereas she has to go to school and has to be the ideal person. The son can look after the horses and that but she, she has to.... The mother is expecting another baby. I think the girl seems to be alone, on her own. I think the girl wishes that she was in the guy's position, there doesn't seem to be a father around. The guy takes care of all the manly duties. The way it ends up is the young girl is doing things to the mother's expectations. She's there for the mother through it all. The son, well he just does his own thing. And that is all I can think of."

Card 3BM

“Something really bad has happened to her. Things have been building up for a while, and now she's lost control. She's crying her heart out. She can't handle it anymore. She feels hopeless and tired. She's tired of everything. She wants to give up. The way I see it she ends up in hospital having a nervous breakdown or committing suicide. She lands up in hospital. She is hospitalised.”

Card 4

“He's angry with his wife for doing something, she's had an affair? She's trying to talk to him but he's ignoring her. She does care about him and he her. I think they sort it out”.

Card 5

“This is a mother checking up on her daughter and son to see what they're doing. She's suspicious, she wants to know whats happening. The girls exercising. She walks in and they have a massive argument. The daughter feels guilty about what has been done. They don't speak for about three hours. Then they start speaking. The girl promises not to do it. She feels like she is letting her mother down. She hates letting her down. Things get worse and it ends up being uncontrollable. She has to listen to her mother. She has to listen or she'll end up in trouble.

Card 7GF

"She and her mother are very close to each other. So close. She might not be wanting to hear what her mother is saying, the way her head is turned. She's sitting there to please her mother and she does what her mother wants. She seems to be holding on to the doll for safety. I think she's going to put up a performance and storm off and her mother's going to get upset and wonder why..."

Card 7BM

"These parents are strict. The father is telling his son what to do. He has other ideas but in the end he ends up doing what they want him to do. Right now its all going through one ear and out the other. Maybe he'll be successful and show them he can do it".

Card 8GF

"The lady is deep in thought. She could be thinking of something that has just happened. She is keeping all her feelings bottled up inside her. She doesn't know where to go. She's not getting support from anyone around her. She's lonely and I think the way it would end is she's going to lose control. She doesn't speak out or say what is on her mind. She loses control or she seeks help. She, her problems do get solved and on the other hand she could maybe have a break down. She looks innocent but when the anger's out she can be aggressive. Maybe she'll go to hospital."

Card 8BM

“ This person’s undergoing surgery. This is horrible, it is like me... It seems like it’s a time of war, there’s a gun there (points to card). Maybe he was shot and they are operating to get the bullet. I think that after this his life was destroyed because he can’t do what he could do before. In a way he feels he’s let his country down. He is wounded and he can’t go back to war. I don’t know what this person’s doing. He hasn’t also had an operation. I think this place does help them to recover. They are taken care of. I don’t know...”

Card 13MF

“An old man, he’s by his wife’s side. She has had cancer or some other terminal illness. They really loved each other. He stuck by her. She was a good person but she passed away and so he is crying. Maybe he is crying because he knows that she is at peace. She does not have to suffer anymore. He has lost his partner, he will miss her.”



guy → how I'm
feeling now
and generally

"insane, too self aware
& insecure
fat, ugly,"




1991

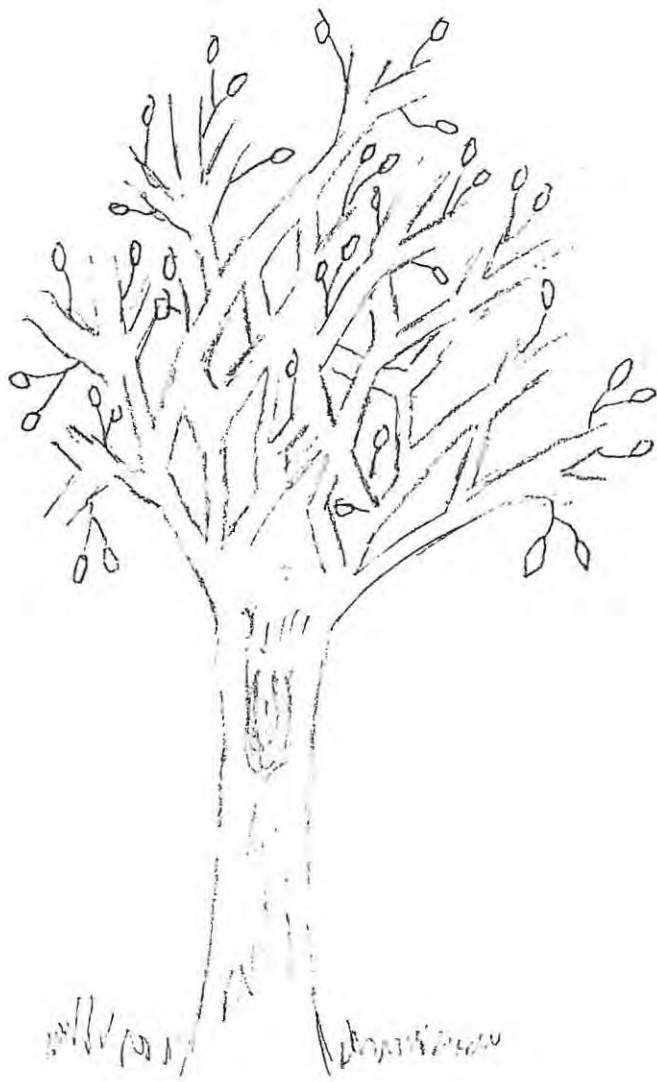


deed
going off to talk
to someone

underneath
umbrella



 swimming (by friends)



"I'm in the window,
looking out."

